RESPONDING TO ALLEGATIONS OF ABUSE. A QUALITATIVE STUDY OF THE INFLUENCES UPON DECISIONS MADE BY NURSE AND SOCIAL WORKERS IN COMMUNITY LEARNING DISABILITY TEAMS IN WALES.

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Responding to allegations of abuse. A qualitative study of the influences upon decisions made by nurses and social workers in Community Learning Disability Teams in Wales.

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Abstract

Background: The abuse of adults with a learning disability has been increasingly monitored and recorded in order to prevent abuse and to intervene when it occurs. What has received less attention is why the incidents that are identified and recorded as abuse are recognised and defined as abuse. Whilst little is known about how the abuse of adults with a learning disability is defined, even less information is available to discuss the influences that nurses and social workers in a Community Learning Disability Team experience in defining and responding to potential abuse. Exploring these influences and the decisions that follow from them is the focus of this study.

Purpose: This research investigates, explores and recognises the choices, decisions and conflicting priorities that nurses and social workers experience in identifying and responding to potential abuse. This study also recognises how registered nurse and social work professionals in a Community Learning Disability Team arrive at a decision as to what action is required to respond appropriately to the potential abuse that they are aware of.

Method: This study follows a qualitative paradigm and symbolic interactionist perspective to value and explore participant interview data. The grounded theory approach of Situational Analysis (Clarke, 2005) – a constructivist method that extends the original grounded theory method – is used to analyse information from 25 semi-structured interviews.

Findings: The findings identify four theoretical categories emerging from participant data. These are; the official line, expectations and perceptions, nonvulnerable adult process responses and lastly confidence and competence. New theory is presented using a project map a unique and disciplined feature of Situational Analysis (Clarke, 2005).

Participants expressed that recognising and responding to abuse was not a clear, linear or straightforward process. Characteristics of each of the theoretical categories may overlap with, or be challenged by, another category. Examples of this included that there was a discrepancy between the clarity of the available

guidance and how it was applied to practice within individual Community Learning Disability Teams. Filtered through the priorities that nurses and social workers identified, the four categories contribute to establishing the theoretical statement the ‘tipping point – practitioner discretion, management decision’.

Conclusions: Policy guidance suggests that the consistent application of single point or threshold at which abuse is defined and action taken is both positive and possible (SSIA 2010, Wales, 2014). This research proposes that there are a number of influences upon practitioners which prompt them to exercise a discretion as to how abuse is defined that may include re-framing incidents so that they that they do not constitute abuse. Where abuse is identified by participants it is likely that a manager – usually a social services manager- will direct or instruct the action that the practitioner should take to respond to the incident.

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Chapter 1. Introduction

The abuse of adults with a learning disability is not a new phenomenon. Abuse of adults at Ely hospital, Cardiff was identified in the 1960's (Committee of Inquiry, 1969). This was quickly followed by a number of abuse scandals in the 1970's. The abuse of adults with a learning disability has continued to be present with abuse identified in 2011 at Winterbourne View private hospital (Flynn, 2012). Despite this awareness or acknowledgment of abuse, no formal coordinated policy approach was launched until 2000, and then separately in England (Department of Health (DH, 2000)) and Wales (National Assembly of Wales (NAW, 2000)). This PhD study explores the responses, and influences upon responses, that nurses and social workers in Community Learning Disability Teams (CLDTs) experience when they become aware of potential adult abuse. Community Learning Disability Nurses (also referred to from here as nurses) and social workers are core (and consistently present) members of the CLDT. Individual adults with a learning disability may have a nurse and/or social worker allocated to them and this is likely to be determined by the support requirements of the adult. Nurses may have a predominate focus upon health promotion and interventions whilst social workers are more likely to be 'supporting individual networks of support around vulnerable adults' (Hunter and Rowley, 2015, p110).

The abuse of adults is an under-researched area (Graham et al., 2014). Manthorpe et al. (2010) expressed that there is little understanding of how abuse occurs and is managed in settings where professional staff are in place – a key focus of this study. It is this lack of existing knowledge and the need to develop safeguarding practice, that has prompted the research question: *What influences decisions made by nurses and social workers in CLDTs in Wales when responding to potential allegations of abuse?* This first chapter introduces the background and context of both the study and the researcher.

The significance and timeliness of the research are acknowledged and the structure of the thesis then follows.

1.1 Background and context to this study

Abuse is defined in *In Safe Hands* (NAW, 2000) as an incident that causes significant harm to an individual defined by the guidance as vulnerable – whether or not they may be aware of the incident. Abuse may take the forms recognised in Wales of physical, sexual, financial, emotional and neglect (NAW, 2000). It is recognised in this study that not all adults with a learning disability are vulnerable or are considered to be a vulnerable adult by the *In Safe Hands* (NAW, 2000) guidance. This study acknowledges how vulnerability is understood by nurses and social workers, and how such understanding contributes to their responses to abuse. As use of terms and language may vary between participants, geographical areas and across health and social care, clarification of the key terms used and applied within this thesis are included in a glossary (Appendix 10).

This research study was undertaken in the geographical area that is served by four Local Health Board (LHB) areas and the corresponding ten Local Authority areas. The National Health Service (NHS) and Local Authorities are both expected to work to the principles and directions of the *In Safe Hands* (NAW, 2000) guidance and to be partners in preventing and responding to abuse. The use of the word partnership is to indicate equity and the importance of shared responsibility in adult protection practice. However, within this partnership the expectation is that the Local Authority will have the responsibility to coordinate the prevention and detection of abuse and responses to it. How these expectations are understood by nurses and social workers, and influence the decisions that are made when working with individual adults with a learning disability forms the basis of this study.

1.1.2 Situating the researcher

This study was prompted by my interest and practice experience as a registered social worker, although not as a social worker in a CLDT. As a social work

practitioner, I was aware that seeking advice from the Local Authority to explore dilemmas, discussions and disagreements regarding allegations of abuse had increased, and that this was encouraged as good practice. As a registered social worker, I am involved in adult safeguarding decision-making and practice largely from the perspective of trainer, investigator or Designated Lead Manager (DLM). In undertaking these roles, I was aware that there was little accessible, research–based information to inform my social work practice. I was also aware that without a rigorous knowledge base there was a possibility that responses could be inconsistent, inequitable and shaped by local priorities, and not the needs of vulnerable service users who may require protection. As a social work practitioner, I was aware of the day-to-day conversations about risk that took place in a social work office but was unclear how, when, and why these resulted in the action that followed. As a Designated Lead Manager in the adult protection process - chairing and coordinating multiagency responses to alerts/referrals raised – I was aware that alerts covered a range of incidents and that the referrers of these incidents expressed significant differences in the priority of anticipated response. This inconsistency prompted my interest in this research project, not least as the referrals that I was asked to review had been identified as incidents of significant harm – the threshold for abuse in the *In Safe Hands* policy (NAW, 2000). How incidents were assessed as meeting this threshold, as well as incidents that were assessed to not reach the threshold have both a practice and research interest for me. At an early stage of practice to research experience it is my view, gained through social work experience that without recognising the influences upon nurse and social workers when responding to potential abuse, opportunities to respond to the abuse of adults with a learning disability may be missed. As a social work practitioner prior to and throughout the study, my research interest was prompted by practice experience. Throughout the PhD study process, I have recognised and reflected upon the potential conflict between practitioner and research roles. For this reason, throughout the thesis a reflexive approach was utilised.

1.2 Significance of this study

This study addresses a gap in the available literature regarding influences upon nurse and social worker decision-making when an incident of potential abuse is identified. The context of practice in Wales is significant, acknowledging that learning disability practice in Wales has a different history to other parts of the UK. Just as devolution has informed and will continue to shape current policy and practice in Wales, it is likely to influence future policy and practice. The development of theory assists in understanding how nurses and social workers experience the reality of making decisions about determining when an incident constitutes abuse and requires an alert to be raised. In developing and presenting new theory, this PhD study makes an original contribution to the knowledge of both learning disability and adult protection.

1.3 Aims and objectives

The overall aim of this research study was to identify what influences decisions made by nurses and social workers in CLDTs in Wales when responding to potential allegations of abuse. This was achieved by a number of specific objectives.

1.3.1 Objectives of this study

The objectives of this study were to:

- Explore influences upon social worker and nurse decisions that relate to adult abuse/adult protection.
- Explore why action is taken or not taken when abuse may be indicated.
- Explore nurse and social worker experience of working together to respond to abuse.
- Explore nurse and social worker perspectives on how legislation, policy, and guidance are used to assist in responding to abuse.

1.4 Organisation of the thesis

This thesis consists of seven chapters written in the third person, except where personal reflection or reference to personal experience is included. A literature review is presented providing the background and context to this study (chapter 2). It includes an overview of the adult protection research landscape and identifies a gap in current knowledge relating to adult protection decisionmaking by nurses and social workers in a CLDT. The specific experience of learning disability practice in Wales, and subsequent lack of Wales specific evidence is also acknowledged.

Methodological considerations and the research design are then considered (chapter 3). A discussion of the choice of constructivist grounded theory is provided - recognising the advantages and identified limitations of alternative approaches. Having considered a range of qualitative methodological responses, Situational Analysis (Clarke, 2005) (a version of grounded theory) is presented as an appropriate, modern, and credible choice for this study. Using the Situational Analysis (Clarke, 2005) grounded theory method, this study not only identifies gaps in existing adult safeguarding evidence but also that there are unarticulated and powerful positions adopted by nurses and social workers.

The findings of this study are presented, firstly by presenting emerging ideas (chapter 4) and then presenting the development of four categories and a core category through a series of maps derived from the Situational Analysis (Clarke, 2005) grounded theory approach used for this study. Each analytical stage (chapter 5) is accompanied by further discussion and reference to relevant theoretically sampled literature. A final project map is presented (chapter 6) illustrating the key relationships between the emerging themes and the emerging theory - ‘the tipping point: practitioner discretion, management decision’ (chapter 6).

Lastly, the strengths and limitations of the study are discussed, drawing conclusions as to how the new theory makes an original contribution to new knowledge. How this original contribution links to nurse and social work

practice is considered, where these may contribute to the development of social work and nursing practice are then included as recommendations for further this work. These recommendations include action points for pre and post registration nurse and social worker education and training as well as policy and policy makers. Recommendations for further research are also proposed.

The context for this research and literature that identifies that there is a gap in existing knowledge which this PhD study seeks to address and is outlined in the following chapter.

Chapter 2. Literature review

2.1 Introduction

This chapter reviews the available literature that forms the background to this research study. The chapter first discusses the role of literature in grounded theory and in particular, the chosen Situational Analysis grounded theory method. The chapter then explores the search strategy for the initial literature review followed by an overview of the existing research acknowledging the nature and prevalence of the abuse of adults with a learning disability. A discussion of the legislative and policy framework in which adult abuse practice takes place in Wales, including the changing policy landscape and the influence of international research, follows. Finally, the chapter recognises the context, history and experience of adults with a learning disability in Wales and introduces the role of the practitioner as researcher.

2.2 Role of literature in grounded theory

The position of the literature review is a source of dispute within grounded theory research (Bryant and Charmaz, 2007). Glaser and Strauss (1967) and Glaser (1972) anticipated that qualitative research would be taken seriously as a credible research approach if it followed a similar pattern as natural science enquiry. In laboratory conditions a researcher may undertake research in which he or she would not know the characteristics of the sample under investigation – they would have no previous knowledge of the subject being researched. Consequently, Glaser and Strauss (1967) and Glaser (1972) recommended that literature review should occur after data analysis to ensure that existing knowledge does not interfere with the data analysis process. Later, Strauss and Corbin (1990) considered that prior knowledge of a research topic is inevitable with a literature review being more appropriately placed in advance of undertaking research. Adherents of Glaser and Strauss' (1967) traditional grounded theory approach to using participant data continue to support the position of the later literature review, whilst early exposure to existing literature is supported by others (Layder 1998, Dey 1999). The

growing use of an early literature review is increasingly linked to the need to demonstrate awareness of existing relevant research to complete research funding applications and to indicate that the contribution of the proposed research to existing knowledge.

The chosen constructivist grounded theory method for this study is Situational Analysis - a product of what Richards and Morse (2007) acknowledge to be shifts in the grounded method towards inclusive and interpretive approaches. Whilst dispute about the value of a literature review continues even in constructivist approaches, Clarke (2005), the author of Situational Analysis has no doubts that a review of literature is appropriate at the start of a research project.

Clarke (2005) acknowledges that practitioners in professions are likely to be researching within the field of their work experience. As such, previous knowledge cannot be ignored, especially where it contributes to identifying the need to undertake the research in the first place. Researchers, especially practitioner – researchers, Clarke (2005) advocates, should acknowledge their position and critically explore and challenge the awareness and knowledge that they bring to the project. Clarke (2005) clarifies:

> *' I see prior knowledge of the substantive field as valuable rather than hindering' (p13) [adding that] ' no researcher is a tablua rasa' (p75).*

Knowledge of the field of concern Clarke (2005) offers is important for accountability, both to avoid disregarding existing knowledge and to recognise, in the context of this study, the political context or situation in which social workers and nurses make decisions about adult abuse.

As a social work practitioner undertaking this research, it cannot be overlooked that my experience of being involved in adult safeguarding practice dilemmas initiated interest in this project. I also had views developed through my own practice of how adult protection process and responses are intended to work – acknowledging that this knowledge is itself the product of my own

experience. It was therefore not possible for me to approach this study with no prior knowledge of the subject. This experience promoted an awareness that there was a significant gap in research as to how and why adult protection decisions are made by nurses and social workers in Wales.

The inclusion of a discussion of literature prior to data gathering does not preclude the theoretical sampling of data required by the grounded theory method. The findings (chapter 4) of this thesis therefore incorporate a discussion of theoretically sampled sources. Acknowledging the development of the project, an initial literature review is undertaken here and updated later with a further research discussion in the findings chapter of this thesis.

2.3 Search strategy

Broad searching of existing literature using the University of South Wales (then University of Glamorgan) MetaSearch function was undertaken. Using this search function, a combination of health and social care databases supported by the university in 2012 was used. These included the CINHAL, ASSIA and Ingenta databases (see table 2.1). This search revealed 337 sources between 1983 and 2012, a period of 29 years. With duplicate sources removed, this number was reduced to 285. Appendix 7 demonstrates the returns (with duplicates removed) per combination of search terms.

These dates acknowledge the introduction of a significant policy development in Wales – the *All Wales Strategy for Mental Handicap1983* (Welsh Office, 1983) and cover the time period from this until the year in which the data collection for this project was undertaken. This range of years also includes the years in which adult protection policy and guidance was published in Wales. Table 2.1 indicates the primary and secondary search terms that were used to identify 46 articles directly related to the topic which were all reviewed.

Search strategy	
Databases	CINHAL, ASSIA, Ingenta, (University of Glamorgan, MetaSearch combination)
Search terms	
Primary term	Secondary terms
DECISION	Choice, discretion, motivation, best interests, mental capacity, social workers, nurse.
INTELLECTUAL DISABILITY	Learning disability, Community Learning Disability Team, multidisciplinary team, intellectual disability.
WALES	Community Learning Disability Team, multidisciplinary team, intellectual disability.
ABUSE	Neglect, physical, financial, emotional, institutional, reporting, perceptions, impact, hierarchy, policy, devolution, Scotland, Northern Ireland.
ADULT PROTECTION	Adult, abuse, safeguarding, protection of vulnerable adults (POVA), vulnerability.
ADULT	Adult (not) child.
(not) CHILD	(not) child, (not) children, (not) child abuse.
SAFEGUARDING	Positive, aversion, management, hierarchy, decision, perception, rights, empowerment, autonomy, choice. Duty of care, responsibility, whistleblowing, impact of abuse, code of practice, values, registration, choice, deception.

Table 2.1 The primary and secondary search terms used in this study

The 46 articles identified were not uniquely related to adult abuse or safeguarding issues and adults with a learning disability although they did meet

the inclusion criteria. Whilst these were not excluded from the literature search, it does mean that several sources refer to the abuse of adults who do not have a learning disability. Predominately these sources related to the abuse of older adults but are relevant as adult protection activity for older adults has a similar policy context derived from the *In Safe Hands* (NAW, 2000) guidance. The low number of sources returned is consistent with the review of adult protection literature undertaken by Graham et al. (2014) who used a narrower inclusion criteria of literature published between 2000 and 2013 and identified just 26 sources in this time period that met the inclusion criteria (see table 2.2) for their study. Key journals accessed included the Journal of Adult Protection, The British Journal of Social Work, Journal of Intellectual Disability Research and The Journal of Intellectual Disabilities.

A snowballing sampling technique where articles that identified other relevant research were included and used. Hand searching of relevant journals has also identified further sources that have been included. Repeated searches over the lifetime of this study have been undertaken to supplement the initial search and to ensure that references to literature are contemporary. My skill in searching for literature also developed throughout the study reducing the number of irrelevant articles or articles that meet the exclusion criteria.

All references (including those that later appeared to be less relevant but not excluded) have been retained within the EndNote database-a software package designed for bibliographic management. The EndNote database can be searched by date of article, date retrieved, keywords, author, date of publication or journal title. Use of EndNote has also enabled books, reports, publications and media to be recorded as sources contributing to evidence for this research project.

Recognising that search terms can lead to broader returns than anticipated by the terms entered it was necessary to include and exclude some sources. Of the 337 sources identified, some sources were included but later proved to be of no or little relevance. Examples include where international terms were not applicable to the UK or where the terms had highlighted sources that were not

relevant to the study. The return of sources including the term child or children, although excluded, is an indication of this

These included sources that when explored more fully than the initial search summary met the exclusion criteria (table 2.2). Examples included articles where the lead investigation related to child protection or risk not related to adult safeguarding. International sources have been treated with caution as reference terms and context could not be fully understood in the UK and Welsh context. The dilemmas of including and using international sources are discussed below.

Included	Excluded
Publications in English	Publications not in English.
Research publications that acknowledge ethical issues.	Where no ethical considerations are acknowledged.
Journal articles, books, reports, policy, guidance.	Publications where reference information is incomplete or unavailable.
Research articles in journals are credible (peer reviewed).	
Evidence that relates to 'learning disability' as understood in the UK.	Evidence that does not relate to 'learning disability' as understood in the UK

Table 2.2 Inclusion and exclusion criteria for this research study.

The inclusion and exclusion criteria recognise that not all sources are research publications. Of the 46 sources that were identified using the primary and secondary search terms, all met the inclusion criteria for this study.

It has been necessary to recognise the differences between publications where a system of peer review exists (in order to assess credibility) and publications where this is not an appropriate process, for example policy documents or papers that express an opinion based on practice experience.

Acknowledging that terminology and language has changed over time in the UK and that international use of these terms vary, the terms adult with a learning disability, adult protection are used in this literature review. Both this literature search and those of Graham et al. (2014) confirm that there is little existing research available – especially in relation to the decision-making of staff working with adults with a learning disability.

The terms 'Protection of Vulnerable Adults' (PoVA), 'adult protection' and 'safeguarding', whilst describing different things continue to be used interchangeably in literature; further confusing and complicating comparisons. For these reasons, the literature search terms above include combinations of all terms.

2.4 The nature of the abuse problem

Existing adult safeguarding policy and practice is largely concerned with protecting adults from abuse and reducing the possibility of further abuse once identified. The use of the term *abuse* has been a feature of guidance and policy in England and Wales since 2000 (DH, 2000; NAW, 2000) having featured in inquiries into both adult and childcare practice in the preceding decades. Defining abuse of adults is not straightforward for a number of reasons. These reasons include the understanding of professionals as to what may constitute abuse and that an adult that they are supporting may not match the definition of a vulnerable adult in the 2000 *In Safe Hands* guidance (NAW, 2000). *In Safe Hands* (NAW, 2000, p14) describes that abuse is 'a violation of an individual's human and civil rights by another person or persons.'

This is the definition to which nurses and social workers must refer and apply to their practice in Wales. *In Safe Hands* (NAW, 2000) identifies that there are five recognised categories of abuse which are:

- Physical abuse
- Sexual abuse
- Psychological/emotional abuse
- Financial/material abuse
- Neglect

The All–Wales Interim Policy and Procedures (SSIA, 2010) acknowledges these categories but also prompts practitioners to be aware of incidents that may also contribute to wider safeguarding concerns. These include consideration of domestic abuse, hate crime and discrimination.

2.5 Defining vulnerability

The definition of a vulnerable adult is also contained within *In Safe Hands* (NAW, 2000) and is intended to clarify that the policy applies to adults (over the age of 18) who are:

> *'…or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation.' (p11)*

This broad criterion defines who is, or is not, a vulnerable adult, and where an adult is identified as vulnerable within this National Assembly of Wales (2000) definition the adult protection policies and procedures apply. Where an adult is assessed not to be a vulnerable adult, then the procedures cannot apply. Where an adult is identified as vulnerable and experiencing abuse, an alert or adult protection referral to the Local Authority is prompted.

In assessing whether an adult is a vulnerable adult, practitioners, including nurses and social workers may need to evaluate a wide range of considerations. In so doing, a practitioner may introduce personal opinion and exercise individual discretion in this assessment to define the adult as vulnerable or not. It is how these opinions are derived and this discretion exercised that this research explores. The definitions in *In Safe Hands* (NAW, 2000) are broad which is likely to give considerable scope for local interpretation. Brown (2010) comments that the definitions within adult protection guidance in 2000 for England and Wales were not clear or helpful and that it was left to local agencies to determine which incidents to acknowledge, respond to and investigate.

In Safe Hands (NAW, 2000) is a generic policy that applies to all adults, the intention is that it incorporates and responds to the needs of all adult service users. This may support broader assessment of risk of abuse for all adults and avoid preconceptions about abuse, lifestyle and vulnerability. *In Safe Hands* (NAW, 2000) does not suggest that a health condition or diagnosis, age or disability (or any other characteristic) are in themselves indicators of vulnerability. Instead the guidance directs staff to look at the person's situation and the resources that they have available to them to reduce or protect themselves from the risk of significant harm. Scanlon and Lee (2007) who evaluated vulnerability in the acute hospital setting identified that the phrase was generally applicable to three broad forms of vulnerability: social, physical and psychological. How these characteristics interact for a vulnerable adult with a learning disability may change dependent upon their situation and circumstances, and the capability of the person to anticipate and respond to the challenges posed.

In exploring literature and available policy, guidance and legislation, the difference between child and adult protection becomes clearer. Significantly, a child would not be anticipated to formulate a response to potential abuse to keep themselves safe as might an adult - vulnerability of a child is presumed. *In Safe Hands* (NAW, 2000) expressly relates to adults and requires an individual assessment as to whether a person is vulnerable. With this in mind, Brown (2010) advises that there is a danger in seeing some adults as necessarily and automatically vulnerable.

Nursing and social work literature frequently feature discussions regarding risk and vulnerability (Perske, 1972; Fyson, 2009; MacDonald, 2010) all exploring how much risk is too much risk (and who is the assessor of this) and the right of the adult and practitioner to take risks. Adult protection policy is concerned both with risk (the likelihood that harm may occur) and vulnerability. Whilst all adults can be vulnerable at points in their lives, Sellman (2011) suggests that there are situations in which people are 'more than ordinarily' vulnerable. More than ordinarily vulnerable, he suggests, is likely to refer to people who need health (or equally social care) services to support them. This vulnerability may

not be lifelong – it can occur at some points of an adult's life and not others- for example whilst acutely unwell.

Brown (2010) suggests that vulnerability is likely to be caused by the relationship between the person and their environment but it is only when an abuser is present that the risks associated to the adult's potential vulnerability may combine to cause significant harm. What Brown (2010) does not acknowledge is the potential that the experience of abuse may impact upon other areas of the vulnerable adults' life through loss of confidence and fear of abuse. Tarrant (2003), who reviewed how existing law applies to the sexual abuse of adults with a learning disability, identified that the opportunity for abuse is huge, whilst the risk of disclosure or discovery is low. In this article, Tarrant proposes changes to the legal system and greater understanding by legal representative of adult's right to a private life that could more effectively support and protect vulnerable adults with a learning disability.

Although vulnerability should not be assumed as an inevitable part of having a learning disability (Northway, 2002), practitioners must be alert to the possibility of adult abuse. Adults with a learning disability are recognised to be at 'particular risk of abuse' (Jenkins and Davies, 2011, p32), although the extent and nature will differ between individuals (Northway and Jenkins, 2013). Fyson (2009) recommends that alertness to adult protection should be considered as a central practice principle for all staff supporting adults with a learning disability and that promoting independence, choice and social inclusion alone is likely to be an inadequate response in protecting adults from abuse. What is less clear from existing literature is how practitioners assess and identify vulnerability and the influence that this has on how decisions are prioritised and carried out. Added to this is the confusion that Brown (2010) identified of determining who is a vulnerable adult; and further how local policy and local priorities respond to this and influence practice in Welsh CLDTs.

2.6 The extent of abuse

The difficulty of defining abuse and inconsistences in response cause a difficulty in knowing the true extent and levels of abuse of adults with a learning

disability in Wales. Some adults may have their concerns managed by alternative processes such as criminal justice including hate crime reporting or a complaints scheme that may never join up with the adult protection process despite meeting the definition of abuse. Official statistics of incidence of abuse may only tell part of the story but are helpful as indicators of some of the patterns of alerts that are reported. The monitoring report of adult protection the Care and Social Services Inspectorate Wales (CSSIW) (2013), indicated that there were 4,915 and 4,245 referrals into the adult protection process in 2009-10 and 2011-12 respectively. In 2010, 1,100 concerns regarding the abuse of adults with a learning disability were raised in Wales – a significant over-representation given that only approximately 4% of people in Wales are officially recognised (Welsh Government, 2014) as living with a learning disability. The actions taken as a result of these alerts and the difference that it made for the adults referred is not explored by the CSSIW report. The same CSSIW (2013) report notes that the level of adult protection referrals peaked in 2010-2011. This high rate of referral CCSIW (2013) suggest, could have been influenced by a number of high profile incidents affecting adults with a learning disability in this timeframe. The events that CSSIW (2013) identify include incidents of abuse at Winterbourne View Hospital in 2011 (Flynn, 2012) and the hate crime murder of Steven Hoskin a young man with a learning disability in 2006 which attracted significant media attention related to the conviction of his killers in 2010. The *All–Wales interim policy and procedures* (SSIA, 2010) formally recognised hate crime and hate incidents as requiring an adult protection response as well as that of criminal justice.

The CSSIW report (2013) attributed the introduction of *All- Wales Interim Adult Protection Policy and Procedure for the Protection of Vulnerable Adults from Abuse* (SSIA, 2010) that was introduced in 2011 to a lower number of referrals into the adult protection process across Wales in the 2010-2012 period. CSSIW do not comment upon whether this is a positive or negative association but attribute the link to the greater scrutiny of alerts of abuse which can then be directed to alternative support routes. A reminder here is appropriate that whilst the 2010 *All- Wales Interim Adult Protection Policy and Procedure for the Protection of Vulnerable Adults from Abuse* (SSIA, 2010) was added into

practice *In Safe Hands* (NAW, 2000) was not removed. The 2010 policy supplemented but did not replace existing guidance and the impact on practice attributed to the interpretation of the 2010 guidance requires acknowledgement.

The same report (CSSIW, 2013) acknowledges that some Local Authorities that had participated in the data gathering had reported that the interim All Wales guidance (Social Services Improvement Agency (SSIA), 2010) had introduced a new threshold for adult protection alerts, with more concerns being managed through care management or commissioning departments. Whether raising the threshold at which abuse is reported was an intention of the policy is not clear; instead the policy acknowledges that it was designed to promote consistency across Wales. This indicates that the message or intention of the *All- Wales* guidance may have been interpreted differently across Local Authorities with resulting variations in practice. Achieving or contributing to consistency will require a lowering of the application of the adult protection threshold in some Local Authority areas if the CSSIW (2013) report accurately indicates patterns of tolerance to risk and referral patterns.

Whether high or low referral rates into the adult protection are desirable, or result in better outcomes for adults is unclear. Adult protection referrals are not in themselves indicators of abuse or poor practice - referrals may be encouraged in some Local Authority areas to enable partnership working and to promote accountability or to look at particular patterns of practice. In other situations, alternative mechanisms may be used that respond to risk without an adult protection referral being considered necessary or proportionate. If adult protection referrals are viewed as negative by practitioners or care service providers it may be less likely that referrals are received for fear that it will be viewed as an admission of poor practice, or that a sanction from the Local Authority will follow. As reporting practice varies significantly between Local Authority and partner agencies, there can be no direct correlation between the referrals received by a Local Authority and frequency of abuse experienced. Referral figures or patterns alone are not a full or informed picture of abuse. Upon reviewing the referral, a Local Authority may decide that the

assessment of risk applied by the referring practitioner is not appropriate for the adult protection process and can be resolved in another way. The referral will, however, continue to be recorded as an adult protection concern raised to the Local Authority.

The CSSIW report (2013) provides no assistance to explore why some concerns were raised and prioritised. The availability of a written adult protection process has prompted a review or focus upon its application and use (Beadle-Brown et al., 2010; Collins, 2010; CSSIW, 2013). Such a focus upon the application of policy and use of the adult protection process risks becoming the focus of adult protection literature simply because it is a theme to which greater attention has been paid over recent years. Whilst the application of policy to practice, in particular patterns and trends of referral has begun to be explored, it leaves unexplored how and why individual nurses and social workers understand, explore, and apply these policies to day to day practice. The study outlined in this thesis acknowledges the application of individual decision-making to practice and whether or not policy is identified as an influence upon these.

The mixed picture of reporting concerns of abuse and the inference from CSSIW (2013) that referrals to the adult protection may be influenced by wider issues, raises questions about how adult protection decisions are made. Nurses and social workers have a responsibility to advocate, derived from professional codes of practice (Care Council of Wales (CCW), 2015; Nursing and Midwifery Council (NMC), 2015) on behalf of service users and to report incidents that may be harmful or abusive. Where nurses and social workers keep quiet about harmful or abusive incidents they may be viewed as condoning poor practice. Brown (2010) and Northway and Jenkins (2013) advise that there is very little guidance on this decision point at which action should be taken. Killick and Taylor (2009) who undertook a systematic narrative review summarised that in relation to the abuse of older adults little is known about how professionals make decisions, and that little research has been undertaken to explore this. There are indicators raised by the Killick and

Taylor (2009) review that perceptions of vulnerability are frequently based upon health condition/status or gender and age of the older adult.

Clarifying how decisions are made about the threshold of abuse is vital to understanding how practitioners assess and prioritise risk of harm and ensure an appropriate response. This links directly to the comments of participant service users in the 'Looking into abuse project' (2013) who identified frustration that even when professionals were made aware of concerns about abuse no action appeared to be taken. Understanding why action is taken or not relies upon understanding the decision-making process of the individual nurse or social worker. When abuse is not recognised or where abuse is recognised and no response is made, the likelihood of an adult with a learning disability securing justice through criminal or civil routes is reduced. This research study explores how social workers and nurses in CLDTs in South Wales assess and prioritise the risk of harm and decide upon the action required.

2.7 Identification of abuse

Jenkins et al. (2008) identified that one of the factors that influences nurses in considering an adult protection concern is a 'hierarchy of abuse' with some categories or incidents of abuse being viewed as more significant or severe than others. In the study of Jenkins et al. (2008) that involved 70 participants in focus groups, incidents of sexual or physical abuse were identified as requiring immediate action, although emotional and financial abuse were less likely to secure a priority response. Neglect, the study identified, was largely overlooked as requiring a response (Jenkins et al.,2008). Parley (2010) also identified through a review of literature that adult protection research predominately focusses upon sexual and physical abuse which may further perpetuate the view that other forms of abuse require less consideration. Northway and Jenkins (2013) acknowledge that sexual and physical abuse are likely to be less problematic to gather evidence and are linked to traumatic incidents which may be more straightforward to identify. Furthermore, Northway and Jenkins (2013) add that psychological abuse or neglect are less

likely to be disclosed or noticed if the adult is being relied upon to identify and disclose to a professional the abuse that they have experienced. Financial abuse may be more likely to be identified if there are good records in place and clear authority to manage and undertake financial transactions. No literature has been identified in the search undertaken for this study or reviewed that discusses prevalence and patterns of financial abuse or explores if there is greater evidence of abuse if informal (not legally endorsed) arrangements are in place, such as family members of friends supporting an adult to manage their finances. This is despite prompts in *In Safe Hands* (NAW, 2000) and the *All-Wales Adult Protection Interim Policy and Procedures* (SSIA, 2010) that there is a higher likelihood of abuse when the use of formal financial management arrangements are rejected.

The *All-Wales Adult Protection Interim Policy and Procedures* (SSIA, 2010) recognise the dilemmas around the frequency and intensity of incidents of abuse and directs practitioners to consider these when making referral decisions. Weighing these does not infer that an incident is or is not abuse but that it contributes to a larger picture of risk to which nurses and social workers must be alert. Ensuring an appropriate and proportionate response to incidents of abuse necessitates that the potential for abuse is first recognised by social workers and nurses.

Garner and Evans (2002) studied the difficulties that nurses in a residential setting experience when applying ethical decision-making to issues of abuse. In the same study, Garner and Evans (2002) identified that much of the abuse acknowledged was unconscious or initially unrecognised. The same authors reflect that of nurses referred to their registered body for mistreatment in 1999 few considered that poor practice could also be abuse. Poor practice and abuse are unlikely to be at opposing ends of the spectrum in the significant harm that adults experience. What is not explicit in this study but is inferred is that abuse is perceived by nurses to be purposeful whereas poor practice is not. Therefore, the intention rather than the significance of harm appears to be the identifying feature of defining an incident of abuse in the Garner and Evans (2002) study.

As part of a systematic literature review, Killick and Taylor (2009) discussed a research study of 44 nurse participants in which fewer than half identified incidents of abuse in the case studies that the authors had selected as examples of abuse. From a social work perspective, Collins (2010), in an article based upon practice experience rather than an empirical study, draws a parallel that serious case reviews into major abuse incidents have a recurrent theme that smaller concerns were not recognised, shared and reported. Reflecting upon how nurses respond to initial concerns, Killick and Taylor (2009) offered that possible reasons for this were that nurses considered that they should remain neutral, detached and impartial – characteristics that may conflict with the responsibility of a social worker or nurse as an advocate. Nazarko (2001) confirms that as nurses have a responsibility to speak out about abuse, failure to do so may be viewed as condoning adult abuse or poor practice. Gray (2010) identified that for social workers, professional responsibilities were drawn from codes of practice values and principles of which they must be aware. If Gray is correct in her assertion, the expectation is that social workers use these codes of practice instead of exercising autonomous, professional discretion. The revised codes of practice for nurses (NMC, 2015) and social workers (CCW, 2015) are explicit that practitioners of each profession have a responsibility to highlight abuse or potential abuse as part of maintaining professional standards. However, the renewal of codes of practice alone are not likely to change practice. The Royal College of Nursing (RCN) acknowledging in 2004 (RCN, 2004) that the code of practice was largely disregarded in day to day practice, and Goldsmith (2011) identifying that separate guidance issued by the RCN for safeguarding in addition to the code of practice is a source of confusion.

Commenting upon nurse decision-making in a general hospital, Kitchen (2002) identified that nurses may identify adult safeguarding risks but may not initiate an adult protection alert if they empathised with the alleged abuser. In discussing decisions with doctors about when to raise an adult protection alert the influence of a relationship or empathy with a potential abuser was also identified by Kitchen (2002) as significant. Undertaken close to the date of introduction of adult protection guidance it is not known if this would be an

enduring characteristic over a decade later. Several years after the Kitchen (2002) publication as part of a project group developing a tool for doctors to identify abuse of older adults, Yaffe (2009) recorded the view of one contributor that some types of abuse may be considered to be culturally acceptable by doctors within a specific (but unspecified) community, and therefore not require an alert.

Two distinct challenges are raised by the examples in the existing literature: the reasons that contribute to the identification of abuse and the response by a member of staff when potential abuse is identified. What is clear is that whilst policy recommends collective, multidisciplinary discussion and action, adult protection will always require an element of autonomous professional decision-making and clear understanding of professional responsibilities (Killick and Taylor, 2009; Jenkins and Davies, 2011).

2.8 Decision-making

As autonomous nurse and social work practitioners, professionals are identified as having considerable opportunity to exercise discretion – and to be largely at ease with exercising this when considering potential adult abuse (Taylor and Dodd, 2003; Jenkins et al., 2008). If consistent decisions whether an incident is abuse or not are an intention of the *All – Wales procedures* (Social Services improvement Agency (SSIA), 2010) then understanding discretion in decision-making is essential. Lipsky (1980), who studied and mapped the behaviour of staff in American public services, described that 'street level bureaucrats', (in which he includes social workers and nurses) have considerable policy making powers based upon their day to day roles. These practitioners, he suggests, exercise considerable discretion in their day to-day decisions and make policy work the way that they require (or want) it to for their situation. Ash (2010), commented upon findings raised by an adult serious case review that she had been part of, and identified that social work practitioner discretion results in a wide variation of actions being taken. Evans (2011) explored the use of discretion, reflecting upon Lipsky's view of street level bureaucracy. Evans suggests that the operation of policy and practice are

formed when practitioners are presented with dilemmas that are resolved by their own enterprise (or use of discretion to respond to a situation). This discretion may be applicable to the decisions that adult practitioners in health and social care exercise whether or not to initiate adult protection proceedings.

Evans and Harris (2004) assert that more rules in the form of policy guidance may mean more choices – or discretion - for the practitioner. They offer that discretion, in itself should be understood as neither good nor bad but that it is difficult to manage and can become out of control. Transferred to adult protection, too much discretion in adult protection can either expose adults to additional risk, or can reduce their choice and opportunity (Evans and Harris, 2004).

Whilst individual nurses and social workers have individual responsibilities to respond to abuse they are also members of organisations; the *In Safe Hands* policy (NAW, 2000) commits organisations to adult protection. The expectations and understanding of organisations may differ but if adults are to experience a consistent adult protection response, recognising where the differences are essential. Kitchen (2002) explains that on a general hospital ward there was an expectation that referring into the adult protection process would be undertaken by senior nursing staff, thereby adding in a delay and an additional level of screening to that of the person who had identified the abuse. The effect of such practice is that the decision is deferred to a more senior member of staff. Hudson (2009) suggests that social workers experience a similar powerlessness as individuals and rely instead upon organisational permission to take action and intuition. Webb (2002) who reviewed existing literature relating to risk assessment and social worker decision-making, challenged the evidence base of adult protection assessments undertaken in social services departments. He continued by adding that the existing literature (in 2002) indicated that social workers rely upon vague predictions and uncertain evidence rather than considering and working with possible outcomes (Webb, 2002). Ash (2010) researched social work practitioner autonomy in adult protection decision-making when supporting older adults, and identified that considerable practitioner discretion results in a wide

variation of actions being taken. Ash (2010) identified that social workers described that they sought to secure good outcomes for their service users. What remained unclear to her is how a good outcome is defined by a social worker, whether it is shared with the vulnerable adult, and what influences how social workers define a good outcome. Little of the available research refers to community learning disability staff, drawing instead upon decision-making experiences in other service areas. The *In Safe Hands* guidance (2000) and *All-Wales policy* (SSIA, 2010) apply to all service user groups – however distinctive and different the requirements of adults accessing these services may be.

Where research is available and has explored staff attitudes and motivations to make decisions within a community learning disability team, a focus has tended to explore these within one staff group (Provis and Stack, 2004; Robinson and Cotrell, 2005). Existing research involving these single staff groups has not related specifically to adult protection decisions. This has the risk of overlooking the multidisciplinary dilemmas (and the resulting challenges of consistency) that have been identified as at the heart of the *In Safe Hands* policy (NAW, 2000).

Reports from CSSIW (2010) and Health Inspectorate Wales (HIW) (2010) highlighted differences between health and social services in both the recognition of, and response to, adult abuse. Taylor (2006) acknowledges that these differences are complex and contradictory and unless resolved will restrict positive adult protection outcomes. The CSSIW (2010) and HIW (2010) reports acknowledged this difference and identified that health staff are more likely to use internal reporting structures such as that of a clinical incident to record a concern in an NHS setting. This response, the Department of Health (DH) (2010) suggests, may lead to inconsistent NHS responses and be an inappropriate process in which the impact of adult protection matters upon individuals is under recognised and transparency of response denied. In a Local Authority setting raising concerns about providers, CSSIW (2010) identified was predominately managed by commissioning colleagues,

escalating concerns protocols and provider contract compliance arrangements.

Where alternative processes are used, the opportunity to respond to abuse may be overlooked or dealt with by one agency alone without sharing this information. In turn, Cambridge and Parkes (2004) who considered the role of care management (non – adult protection action) as valuable identified that poor information sharing in any arena where poor practice or abuse is considered is likely to lead to poor decisions for the adult.

2.9 Legislation and policy: a tale of four nations

Whilst recognising that comparisons with child protection may be limited or even unhelpful (Bell et al., 2004) childcare practitioners can refer to explicit legislation when faced with child abuse. Notably, The Children Act 1989 (HMSO) outlines staff responsibilities and duties in law to protect children from abuse. Instead, it is guidance from 2000 that forms the starting point and main reference for adult protection practice, with no legally defined powers or duties to take protective action. The Welsh policy guidance *In Safe Hands* (NAW, 2000) was published simultaneously with the English guidance *No Secrets* (DH, 2000). The two policies largely mirrored each other and reflected a shared starting point, for the implementation of a formal adult protection process. At the time of publication, devolution in Wales was recent and the characteristics of policy direction in their infancy. It was not known how the National Assembly of Wales and *In Safe Hands* (NAW, 2000) would respond to the needs and challenges of the social policy context in Wales. It is possible that although England and Wales both introduced adult protection guidance in 2000, the characteristics and practice in each nation have evolved differently. Adult protection practice has a far shorter history in Wales and the UK than child protection. Like Bell et al. (2004), Duffy and Gillespie (2009) identify that adult and child protection take place in two very separate arenas that may make comparisons between the two impractical or unhelpful. Writing shortly after the introduction of guidance in England and Wales (DH, 2000; NAW, 2000), Pritchard (2001) is less clear that an absolute separation is necessary with

opportunities for adult protection practice to learn from the longer experience of child protection. In Wales, the Social Services and Wellbeing (Wales) Act 2014 (Wales,2014) will prompt the integration of adult and child protection services into integrated safeguarding units. Supporting this is the creation of safeguarding boards intended to mirror the existing structure of the safeguarding children board. How far adult and child protection practice will share and learn from each other's experience is yet to be seen.

With devolution affecting all four home nations through the establishment of the Northern Ireland and Welsh Assemblies (Welsh Government from May 2011) and the Scottish Parliament, adult protection practice has had the opportunity to respond to national and local policy requirements. With the introduction of the Protection of Vulnerable Groups Act (2007) in Scotland (The Scottish Parliament, 2007) it became the first UK nation to recognise adult protection in law moving it from the status of guidance only. It is anticipated that this will change in England with the introduction of the *Care Act (2014)* (Great Britain, 2014) and *the* Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014). Neither Act was in place at the time of data collection for the current study.

In the 2000, *No Secrets* guidance for England (DH, 2000), and *In Safe Hands* (NAW, 2000) clear direction is given that Local Authorities will be the lead organisation for the coordination of adult protection. It is likely that the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) will continue to recommend that local authorities that have a lead role in coordinating adult protection responses, albeit with greater collaboration on a regional basis. Successful adult protection practice (that is intervention that reduces or removes the abuse from the life of the vulnerable adult) the guidance infers, relies upon a series of purposeful relationships across a range of agencies to provide a multidisciplinary response. Core agencies specifically identified in the *In Safe Hands* guidance for Wales (NAW, 2000) to work together are health and social care at practitioner, strategic, provider and commissioning levels.

The social care regulator (CSSIW) reported considerable variation in adult protection practice across Wales (CSSIW, 2010), despite *In Safe Hands*

(NAW,2000) being a policy for all of Wales. This suggests that there are variations between how agencies work together across geographical areas and differences in how decisions about whether to initiate adult protection measures are made. At the time of data collection and data analysis Wales had 22 Local Authority areas, and 7 health boards to which *In Safe Hands* (NAW, 2000) applies. Inconsistent and sometimes inappropriate responses amongst NHS professional staff to abuse were also highlighted by Health Inspectorate Wales (2010) with NHS responses noted as triggering different levels of response across settings – for example in hospital and in the community. Their report also indicated that health employees predominately viewed adult protection as a social care concern (HIW, 2000).

Policy in Wales is influenced both by history and the recent developments of devolution. *Sustainable Social Services: A framework for Action* (Welsh Assembly Government, 2011) gave clear indications that safeguarding adults practice should be developed along the lines of child protection. The same report acknowledged the experience of Scotland in introducing legislation to strengthen adult safeguarding status and practice. The Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) recommends that regional safeguarding boards are developed, reflecting the established practice of safeguarding children's boards.

With the new opportunity to create law in the devolved area of health and social care, the Welsh Government began consultation to introduce the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014). Whilst the Act formalises adult protection practice and process to the status of law, the title of the legislation may reinforce that safeguarding is the concern of the Local Authority. The current local government policy *Sustainable Social Services: A framework for* Action (Welsh Assembly Government, 2011) outlines:

> *'Responsibility for safeguarding is a shared responsibility across a number of statutory partners: the NHS, education and the police, as well as social services…Social services have a*

pivotal role in safeguarding. It is their responsibility to pull partners together but it is not their responsibility alone' (p27).

The role and responsibilities of the Local Authority prior to a referral being received are not clear including whether pre-referral dilemmas and decisions are more rightly placed with the referring organisation, which may include NHS partners. The proposed change from the current terminology used in *In Safe Hands* (NAW, 2000) - *vulnerable adult* and *significant harm* – towards *adult at risk* is likely to have wider implications for practice. These implications may include how adults are defined as eligible for the adult protection process. The new definition of an *adult at risk* is intended to formalise the duties upon agencies, including social services and the NHS to report, cooperate, investigate and share information that contributes to safeguarding adults (CSSIW, 2013).

2.10 An All-Wales threshold for action?

The point at which a professional takes action and defines an incident as abuse is not clarified in the *In Safe Hands* guidance (NAW, 2000). Instead, it is left to the discretion of each professional within an organisation to determine the point in time in which they decide to take action. This point of recognition and action can be defined as a threshold of abuse. The interim *All-Wales Procedures* (SSIA, 2010) seek to increase consistency of practice, notably the threshold for concerns to enter the adult protection process. The recognition of this decision point or threshold of action is only within the past decade starting to feature in adult protection literature and research (Jenkins, Davies and Northway, 2008; Collins, 2010; Northway and Jenkins, 2013). The understanding of how the threshold is assessed and applied to practice has not been explored in Wales, or within the context of Welsh Community Learning Disability Teams. Collins (2010) explains (based on his practice experience as an adult protection coordinator) that establishing an all-Wales threshold for raising an adult protection alert is likely to contribute to consistent and confident practice throughout Wales. Jenkins et al. (2008) acknowledge the challenge of applying a threshold and suggest that some incidents of abuse

will be below the threshold, tolerated and no action (not just adult protection action) taken. If all concerns of abuse and potential abuse enter adult protection, the decision-making is moved from the practitioner into the safeguarding process, appearing to remove practitioner decision-making altogether. This is in contrast with the experience of a group of adults in South Wales with a learning disability who reported that their own experiences of abuse had not been recognised by professional staff and had not been responded to (Looking into Abuse Research Team, 2013).

Given that to raise a concern of abuse – or the potential for abuse – it must first be recognised raises whether a zero tolerance approach to adult abuse and the recognition of abuse may be realistic. Achievable or not, a zero tolerance to abuse may have the effect of reducing an adults' opportunity to take risks that may prove to have a positive outcome for fear that the action may be considered negligent and abusive. Where a zero tolerance approach may be useful is in setting an expectation to staff, adults with a learning disability and to potential perpetrators of abuse that concerns about abuse will be taken seriously and action will be taken to respond to allegations or disclosures.

In a study that included a range of Local Authority staff (n=56) and NHS staff (n=11), McCreadie et al. (2008) recognised that the identification of what is and isn't considered abuse can be a far from straightforward process for a number of competing policy and practice reasons. Referring to the English *No secrets* guidance (DH,2000), McCreadie et al. (2008) identified through a series of interviews and audit of available guidance that the policy was ambiguous, leaving considerable room for local interpretation and implementation and are cautious that policy guidance can overcome differences in working styles, cultures and power relationships. Although difficult to dispute or disagree with the aims of the policy, differences in interpretation and expectation, particularly at a local level are suggested possible sources of conflict.

Whilst *In Safe Hands* (NAW, 2000) formalised an adult protection process there was no national practice guidance to accompany it, leaving local implementation to local authorities and partner agencies. Mitchell and

Glendinning (2008) reflect that policy itself is usually a compromise between high aspirations and what is achievable in practice. Whilst the threshold guidance in the 2010 *All – Wales policy* (SSIA, 2010) can be viewed as mechanistic or simplified, it is an attempt to respond to comments that adult protection policy has been high on process and low on practicality.

In relation to adult protection research, Manthorpe et al. (2010) undertook interviews with Social Services managers in 26 Local Authority areas in England and Wales and reflected that there is little existing literature regarding how views about safeguarding actions in partner organisations are developed and applied to practice. Indeed, it is not certain to Manthorpe et al. (2010) that adult protection practice was a priority to all practitioners involved in their study. The comments of Manthorpe et al. (2010) demonstrate that although ten years of explicit adult protection policy have passed in the UK, the evidence base for adult protection decision-making remains unclear.

2.11 International perspectives and research on adult safeguarding

Whilst there are slowly increasing levels of adult safeguarding research undertaken outside of Wales and the UK, the knowledge base from which it is starting is slight. Adult abuse definitions vary internationally (Northway et al., 2013) and comparisons must be made with caution. Just as definitions of abuse may be incomparable, so too the roles of social workers and nurses and the expectations of their employing agency may vary. However, whilst accepting that these international sources were researched and developed in their own political, social and cultural context there may be themes that prompt consideration of similar issues, responses or experience in South Wales.

Within Wales alone, CSSIW (2013) identify variations in the application of the same *All-Wales* policy derived from *In Safe Hands* (NAW, 2000). In an international context, the opportunity for difference and divergence in practice may be further magnified. Variations within the application of the same *AllWales* Interim Adult Protection Policy and Procedures (SSIA, 2010) to practice are recognised by CSSIW (2013). Northway et al. (2013) identify the themes of defining and categorizing abuse and the use and quality of official

statistics as areas that make comparisons of international approaches problematic. In addition to this, Northway et al. (2013) recognise that comparisons of international perspectives are difficult as they incorporate different cultural and policy frameworks. These differing frameworks may exclude incidents and categories that are a priority in practice and legislation in Wales but not in the country in which the research was undertaken.

The influence of European and International legislation upon the domestic UK and Welsh context is undeniable. European Human Rights legislation forged in Strasbourg has entered into the Mental Capacity Act 2005 (Great Britain, 2005) and is directly present in the Human Rights Act (Great Britain 1998). Reconciling international expectations with local practice is part of the changing policy landscape in which nurses and social workers in a CLDT practice.

2.12 Language

Having reviewed research and wider literature it is also important to consider specific issues relating to people with learning disabilities such as policy and service provision. A further challenge is that the language around adult protection is evolving. The references in *In Safe Hands* (NAW, 2000) are to Protection of Vulnerable Adults (PoVA) and adult protection with a predominant focus upon process and response to abuse. Northway and Jenkins (2013) discuss that the term 'protection of vulnerable adults' could be perceived as negative and to portray adults as passive. They add that use of the term in policy 'was often interpreted as addressing abuse and neglect once it had occurred, rather than preventing it from happening in the first place' (2013, p89). The term 'adult protection' has been increasingly used to refer not just to the process of responding to abuse but to broader incidents that may place an adult risk. The term may also be viewed as reactionary rather than preventative and pro-active. Instead the development of current terminology is towards the use of the term 'safeguarding'. The Improvement and Development Agency & Centre for Public Scrutiny describe the use of the word safeguarding to be;

> *'a range of activity aimed at upholding an adult's fundamental right to be safe…Safeguarding involves empowerment, protection and justice.. where abuse has occurred and other activity designed to promote wellbeing and safeguard the rights of adults' (2010, p4).*

Whilst adopting the term 'safeguarding' the NHS description (DH, 2011) is broader and includes activities that both prevent abuse and contribute to a multi-agency response when abuse occurs. Reece (2010) describes that although a change of language is helpful, it can only be helpful if it is linked to changes in practice. Whether a change in terminology and a change of practice have occurred together has not been possible to ascertain. Recognising that this study is focussing upon responses to potential abuse the terms 'adult protection' and 'safeguarding' are both used.

2.13 Learning disability and vulnerability

Having reviewed safeguarding and adult protection research and literature more generally, it is also important to consider specific issues relating to people with learning disabilities such as policy and service direction.

2.13.1 What is a learning disability?

The disputed language regarding 'learning disability' requires some acknowledgement as the use of term can be unclear or confusing. A number of different terms are used which include 'learning difficulty', 'learning disability', as well as terms that are now considered out of date and unacceptable such as 'Mental Handicap' (Foundation for People with Learning Disabilities, 2013). Emerson and Heslop (2010) acknowledge that the term 'learning disability' was introduced to replace the term 'mental handicap' although the terms 'learning disability' and 'intellectual disability' should be considered interchangeable in the UK.

The use of the term 'learning disability' as applied in the UK is noted by Heslop and Emerson (2010) to be unique adding that Canada, the USA and Australia now use the term 'intellectual disability'. The term 'learning disability' remains

the preferred term by some adults and carers, although it may be viewed as inadequate by some people with greater support needs to accurately reflect the complexity of their situation (Foundation for People with Learning Disabilities, 2013). Added to this confusion is use of the term 'learning difficulty' or 'specific learning disability' in the UK to describe conditions such as dyslexia, dyspraxia or dyscalculia which for the person 'do not have a significant general impairment in intelligence' (Emerson and Heslop, 2010, p1). People with specific learning difficulties are not considered in the UK to have learning disabilities. The use of the term 'learning disability' in the USA to refer to people who in the UK would be recognised to have specific learning disability (Emerson and Heslop, 2010) means that comparisons incorporating the term 'learning disabilities' in the USA are unlikely to be helpful.

The search criteria used for the research project acknowledge the use of the terms 'learning disability' and 'intellectual disability' as an inclusion/ exclusion criterion for evidence. Learning disability is not determined by one factor, although the use an intelligent quotient (IQ) score at less than 70 has been accepted as a common, (British Institute of Learning Disabilities, 2011) although not problem free indicator.

The most widely cited definition of a learning disability is included in the white paper for England 'Valuing People: a new strategy for learning disability in the 21st century (DH, 2001). It indicates that learning disability is defined by:

a. a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence).
b. a reduced ability to cope independently (impaired social functioning).
c. which started before adulthood with a lasting effect on development' (DH, 2001, p 14).

These characteristics, in isolation or combination, may prompt a consideration as to whether an adult with a learning disability has the potential to be additionally at risk of abuse.

Wales history and the development of *All- Wales Strategy* (Welsh Office, 1983) reflects a different starting point and direction and to that of the rest of the UK. In the 1970's, the suitability of institutional care for adults with a learning disability was being challenged. In 1969, allegations and incidents of abuse were noted at Ely hospital in Cardiff prompting calls for change. The *All-Wales Strategy* (Welsh Office, 1983) predated changes in the rest of the UK and was recognised to be a visionary initiative aimed at securing a full life in the community for adults with a learning disability. In brief, it was envisaged that adults in Wales, with a learning disability would enjoy the same rights and opportunities as their family members and friends and that these would be supported by the CLDT. Established as a single point of contact for people with learning disabilities and their families – the history and purpose of the CLDT is discussed later. CLDTs existed before safeguarding policy and have a longer history of multidisciplinary working than counterparts in other areas of the UK and colleagues supporting other adult service user groups. Given this longer history of multidisciplinary working CLDTs should be well placed to promote safeguarding practice. With little research in this area, it has been necessary to look at wider research incorporating multidisciplinary working, beyond the immediate setting of the CLDT. Recognising the prevalence of learning disability in Wales and then acknowledging how the unique history of learning disability practice in Wales contributes to current CLDT configurations are discussed next.

2.13.2 Prevalence of learning disability

It is difficult to reliably identify how many people live with a learning disability (Emerson et al., 2011). This is because there are difficulties and inconsistent assessment approaches, varying definitions of learning disability and differences in maintaining accurate records or registers of people with a learning disability. Official statistics are predominately drawn from health and social services registers of adults with a learning disability using their services. As a consequence, it is likely that a number of people are not represented as they are not known to services or are not currently using services.

Applying IQ assessed as under 70 as an indicator, Gates and Ioannides (2005) commenting upon a UK perspective indicate that two to three percent of the population live with a learning disability. Emerson et al. (2011) indicate that of people registered with a GP in England 4.3 in every thousand were recorded by their GP as having a learning disability in the year 2010/2011. Welsh Government figures issued in 2013 (Welsh Government, 2013) indicate that at 31st March 2013, 12,260 people over the age of 16 were registered with a Local Authority as having a learning disability. For the same period, the population in Wales was recorded to be 3,082,400 (Statistics for Wales, 2014). Using these figures, the prevalence of people in Wales with a learning disability over the age of 16 is 4%. Whilst figures produced by the Welsh Government recognise age 16 as adulthood the adult protection guidance *In Safe Hands* (NAW, 2000) recognises adulthood at the age of 18. Some inaccuracy is therefore associated with the 4% figure representing the number of adults with learning disability in Wales. Given the increasing number of people in Wales living with a learning disability and that the majority of adults are living in the community, new skills are required to ensure that adults have every opportunity to set the direction of their own lives. To respond to changing demographics and the changing requirements of adults in Wales different responses will be required. As core members of the CLDT, the roles of nurses and social workers will need to change. The CLDT remains the key service to coordinate support for adults with a learning disability

2.13.3 History of learning disability developments in Wales

The history of people with learning disabilities in the UK and in Wales influences current approaches, development and practice is relevant to this research project. An understanding of these changes is essential to nurse and social work practice in Wales. People with learning disabilities have historically, been viewed from the perspective of the medical model. This model considers that people who are considered as ill, require a medical intervention to return them to health (Oliver, 1990). A challenge to the medical model first arrived in the 1960's with the arrival of a Scandinavian model of normalisation developed

by Nirje (1980). Between the 1970's and 1990's the model transferred from Scandinavia, Australia and the USA and a number of modifications took place. By the late 1980's the American influenced normalisation of Wolfensberger (1983) was gaining prominence with an emphasis upon general social theory, integration, age and cultural appropriateness with explicit expectations of typical patterns of daily life.

In Wales, the introduction of the *All–Wales Strategy* (Welsh Office, 1983) was the first commitment to the theory of normalisation in Britain (Felce et al., 1998).

The commitment in Wales, Felce et al. (1998) explain, was to the Scandinavian normalisation of Nirje (1980) with a focus upon everyday patterns of life and living a life much like family and friends and who do not have a learning disability. With the *All–Wales Strategy* in place (Welsh Office, 1983) Wales was earlier adopting normalisation that the rest of Britain, and when normalisation was introduced into the rest of the UK it was predominately influenced by Wolfensberger's (1983) American and more prescriptive approach. Whilst recognising that Wolfensbeger's normalisation had been a major change in learning disability practice, Brown and Smith (1992), suggested that the expectations of normalisation were too restrictive and that instance upon fitting in with 'normal life' could lead to further discrimination.

The influence of normalisation was also evident in changing social policy recommendations and approaches. The *Report of the Committee of Inquiry into Mental Handicap Nursing Care* (1979), otherwise known as the Jay Report, recommended that long term institutional care, such as hospitals, was not meeting the requirements of adults with a learning disability and that better opportunities should be available in the community. Mitchell (2003) reflects that by 1979, nursing staff as the dominant profession in long-term hospitals bore much of the criticism and association for practice within them. A central suggestion of the report recommended that learning disability nursing be phased out. Although the recommendations of the Committee of Inquiry (1979) were revised by 1980, Mitchell (2004) suggests that the conversation and

controversy it prompted caused learning disability nursing to later develop in its' own right.

The social model of disability is broadly the opposite model to the medical model - it views the world rather than the person (and their health conditions) as the barrier to social inclusion. Conversely, the medical model views people with a disability as inevitably dependent. A tension exists that Sharkey (2000) explains; that is that the social model of disability has only had limited impact within the field of learning disabilities. The greater influence he explains was that of American style normalisation. Largely attributed to Wolfensberger (1972), normalisation intended to promote all people as equal citizens, with equal roles and access to the socially valued roles, such as work and daily routine. Although normalisation is now considered outdated in the UK, it was evaluated by Brown and Smith (1992) to be the best available model at the time.

Williams (2007) offers that the roots of contemporary Welsh learning disability policy can be traced back to the *All-Wales Strategy for the Development of Services for Mentally Handicapped People* (Welsh Office, 1983) and characterised as interventionist. Evans et al. (1994) describe that the policy was considered progressive as it brought together significant resources for service development with the leading philosophy of normalisation. The *AllWales Strategy for the Development of Services for Mentally Handicapped People* (Welsh Office, 1983) incorporated a move from institutional to community care. Significantly, concerns raised about hospital care, including the inquiry into abuse at Ely hospital in Cardiff reinforced that institutions were an unsuitable provision of support for people with learning disabilities (Northway and Jenkins, 2013). It is against this social policy background that adult protection practice in Wales has developed.

2.14 Multidisciplinary Team and the Community Learning Disability Team

In Safe Hands (NAW, 2000) and the English guidance *No Secrets* (DH, 2000) recognised and promoted multi-agency approaches as a key element to prevent and to respond to abuse. CLDTs pre-date the *In Safe Hands* (NAW, 2000) policy as they were formed as part of the All–Wales Strategy in 1983 as a single point of access to health and social care. Although the compositions of CLDTs may vary across Wales, social workers and nurses are a constant presence and each area of Wales has a CLDT.

The English guidance (DH, 2000) suggests that working together will enable agencies to provide a consistent and effective response to concerns. The *All Wales policy* (SSIA, 2010) and the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) continue to identify multidisciplinary work as crucial to safeguarding. Whilst the Act (Wales, 2014) requires Local Authorities to promote opportunities for cooperation between relevant partner agencies - including the NHS - these partners are expected to contribute fully to the delivery of wellbeing outcomes (Care council for Wales, 2015a).

It is significant that the guidance (DH, 2000, NAW, 2000) in place refers to multidisciplinary practice rather than inter-disciplinary practice with the multi being a reference to many. Northway and Jenkins (2013) note that in multidisciplinary work, members tend not to cross professional boundaries or adapt their own roles. Conversely, inter-disciplinary or inter-agency working suggests a willingness to cross professional boundaries and roles, knowledge and skills are likely to be shared or adapted to meet the needs of the service user (Northway and Jenkins, 2013).

Boon et al (2004) describe seven models of team working and summarise these as; parallel, consultative, collaborated, coordinated, multi-disciplinary, interdisciplinary and integrated. Boon et al (2004) place the seven types of team on a continuum from groupings of individuals in the parallel model to teams that share both a common philosophy and common respect for each other's

professional input in the integrated model. Finlay and Ballinger (2008) identify that health and social care teams usually most closely resemble a collaborative team (where information is shared informally regarding individual adults in common). In CLDTs in this study the model of team life described by participants is, broadly, closer to that of a coordinated team, where meetings for the purposeful sharing of information are held and actions for specified professionals agreed. Boon's (2004) continuum from consultative to integrated teams, Finlay and Ballinger (2008) suggest is likely to reflect an equivalent continuum of hierarchical team practice moving towards genuinely integrated practice.

No preference is offered by Boon (2004) or Finlay and Ballinger (2008) as to whether one model of teamwork is better than another. Simply, the suggestion is that the context in which the team operates and the decision to be made are likely to determine (or at least influence) the style of decision making.

Emergency duty teams, or acute hospital settings, for example, may require quick decision making as a core skill. However, if decisions are consistently made by the same professional group it may lead to the reinforcement of hierarchy and subsequent disempowerment of other staff within the team (Finlay and Ballinger, 2008).

In terms of adult safeguarding practice Galpin and Hughes (2011) note the criticisms raised in serious case reviews that professionals – and the decisions that they make - have been too detached to be effective. In raising concerns about abuse Galpin and Hughes (2011) encourage the development of a

'decision – friendly' team environment (p153) where multi-agency information can be shared.

The *All–Wales Strategy for Mental Handicap* (Welsh Office 1983) had at its centre the establishment of Multidisciplinary Community Teams (later to be renamed Community Learning Disability teams – CLDTs). Felce et al. (1998) discuss that multidisciplinary teams were a new development and that there was little available experience in Britain to assist with developing process and practice. Even 20 years later Payne (2000), described that the development of

multidisciplinary teams is further complicated by multiple meanings ascribed to the terms 'team' and 'teamwork', suggesting that there is no single formula for building a (successful) team. If a single formula were available and applied to how health and social care professionals operate it is unlikely to be able to appreciate and respond to the changing demands of current practice expectations.

The World Health Organisation (WHO) report on adult abuse, confirms in relation to older adults 'confronting and reducing elder abuse requires a multidisciplinary approach' (2002, p3). Donovan and Regher (2010) writing a decade after the introduction of *In Safe Hands* (National Assembly of Wales, 2000) agreed that a 'multidisciplinary approach is required to confront and abuse and neglect' (p174). Albeit drawn from interviews with social workers in a Canadian context, Donovan and Regher (2010) advocate that uniprofessional responses deny the complexity of abuse and that there are considerations both legal and ethical that may be better addressed by other relevant agencies or professionals.

The spirit of the guidance (NAW, 2000) is that multi-agency decisions are good decisions, that will lead to a clear, consistent and agreed way for staff to respond to abuse and a good outcome for adults. Where policy can be described as low in practical detail on how to define and respond to abuse, research from the literature search has been used to explore the experience of multidisciplinary teams. With little CLDT and adult protection specific information available, it has been necessary to include multidisciplinary evidence from the wider adult protection sources. In Wales, these multidisciplinary CLDTs were based within social services departments, reinforcing the principle that care and support to adults with a learning disability should be based in the community. CLDTs in Wales have a longer history of joint work between health and social services and can reasonably be expected to be in a good position to implement safeguarding policy and practice. Despite this history, it has not been possible to identify significant research in this area.

Croft and Beresford (2002) are cautious that multidisciplinary work in itself will lead to a shared, universal safeguarding decision. They explain that

disagreement is an understandable (and potentially necessary) feature of multidisciplinary meetings. Taylor and Dodd (2003) note that contradiction and conflict are features of the differences of health and social care. Whereas, Taylor and Dodd (2003) offer this as a negative characteristic that inhibits multidisciplinary work and may lead to under reporting of abuse. There is also the possibility that different views may instead contribute to a more satisfying outcome for the adult involved. Reuben et al.(2004), writing from a medical perspective, acknowledge that forming teams can be problematic and can lead to a blurring of roles and responsibilities with the potential to lead to inaction. The history of teams and professions may also influence the work of multidisciplinary teams in that all of the hierarchies and expectations that exist in day-to-day activity are brought into the safeguarding arena (Reuben et al., 2004). Defining the success of multidisciplinary teams in safeguarding adults is problematic for a number of reasons; the adult themselves may not be in agreement to the adult protection process proceeding, professionals may not agree with or carry out the agreed actions. Equally, individual nurses and social workers may feel confusion about whether discussing safeguarding action is appropriately matched to their professional role and experience. As Macdonald and Macdonald (2010) reflect, decisions around risk are often framed in terms of a 'right' answer with an expectation that in a multidisciplinary setting a right answer will, emerge. That is, as Galpin and Parker (2007) offer further to their review of application of adult protection practice in a mental health setting, only if a shared understanding of terms such as abuse can be identified and agreed by the professionals involved.

McNeil, Mitchell and Parker (2013) identify that where multidisciplinary projects have failed (although failure is not defined) in the Australian health setting it has been associated with threats to professional identity. In that research McNeil, Mitchell and Parker (2013) interviewed health professionals who although recognising advantages to inter-professional practice explained that it could be detrimental to team performance and even lead to conflict between professional colleagues. Whilst McNeil, Mitchell and Parker (2013), were describing participant views of multidisciplinary working not specifically safeguarding discussions, the idea that maintaining the performance of

professional groupings at the expense of multidisciplinary practice is a challenge to the multi-disciplinary practice is shorthand for good practice.

Finlay and Ballinger (2008) challenge the advantages claimed for teamwork for the delivery of comprehensive care and treatment. They suggest that the service user may experience contradictory 'expert' advice and that, paradoxically a negotiated division of labour between professionals can lead to fragmentation of support, rather than a holistic, well-coordinated experience

(Finlay and Ballinger, 2008). Leathard

(2007) is similarly cautious that the pressure to form multi-disciplinary teams is unlikely to dissolve organisational boundaries but may instead create new ones. Potentially these new boundaries may be created to ensure personal survival and professional recognition. With safeguarding responsibilities emerging as already fragmented, further division may have the potential to be a barrier to timely safeguarding practice.

In the UK context, Hudson (2002) writing in a peer reviewed journal from a nursing (but not CLDT) perspective reflected that team working (in that study between general practitioners, community nurses and social workers), the very foundation of adult safeguarding practice, has not generally yielded great success. This may be further complicated in adult protection work where multidisciplinary teams form temporarily in relation to one adult. Comparisons with other health and care teams require caution. In Wales, the multidisciplinary CLDT was viewed as essential to coordinating support to families and avoiding conflicting information and guidance being given by a number of practitioners from different agencies. Referring to Northern Ireland, Barr (2006) identified that since 1992 learning disability nurses had been less visible within primary care settings and increasingly associated within learning disability and social services networks.

The configuration of CLDTs vary across Wales with participants identifying that they worked in a range of different multi-disciplinary team arrangements across South Wales.

Whilst participants referred to being a member of a team (however strongly or tenuously) it is the decisions that individual team members/participants make (rather than the structure of the teams within which they work) that are the focus of this study.

2.14.1 Individuals and the team

Any multidisciplinary team is made up of individuals; this research project focuses upon nurses and social workers in a CLDT. Whilst the membership and integration of the CLDT may vary across Wales, nurses and social workers remain a constant. Killick and Taylor (2009) who undertook a systematic review of adult protection practice literature, identified that even as part of a multidisciplinary team, an element of autonomous professional decisionmaking is required. Davies et al. (2011, p38) describe that a registered nurse should 'have a clear understanding of their professional responsibilities.'

Acknowledging that CLDTs are comprised of individual nurses and social workers the roles of whom may also be changing and evolving to respond to changing requirements. These changing requirements may include the need for increased awareness of adult abuse.

Writing in 2006, Barr indicated that learning disability nurses have increasingly large caseload commitments supporting adults with complex physical and mental health needs and are consequently less likely to effectively discharge people from the CLDT. If this pattern remains relevant this could reduce the time that a nurse has to spend with adults with a learning disability, in turn restricting the opportunities to identify and explore possible poor practice or abuse.

In Safe Hands (NAW, 2000) names the Local Authority as having a coordination role. How Local Authorities and the NHS work together to safeguard adults and make decisions therefore needs to be understood. With little evidence arising from adult protection research, the experience from day to day practice is referenced here, noting that comparisons may not be entirely relevant and may be inappropriate when applied to adult protection practice and leadership.

The British Medical Association (BMA) published guidelines for GPs recognising that there was a 'pervasive sense…that the NHS was failing to own the concept of adult protection' (BMA, p3). Similarly, the Health Inspectorate Wales report (2010) identified that there was reluctance to use the adult protection process. The publication of *Clinical Governance and Safeguarding: an integrated process* by the Department of Health (2010) acknowledged that the prevention of and responses to abuse had not become part of established NHS practice.

2.15 Summary

There are some methodological considerations to be recognised in the research the studies reviewed. Several sources are small-scale projects in specific geographical areas, for example Ash, (2010) whose research was based in South West Wales. Equally, reliance upon information that was developed for another purpose, may prove a limitation to its usefulness. Official statistics and reports may only represent adults who are known to services – be they health or social services or their associated agencies. Further, the usefulness of official statistics in research is problematic, as they may not be systematically recorded for this purpose. This is an important acknowledgement as adults who may not have been formally assessed or recognised as having a learning disability will be excluded. The history and evolving politics of supporting adults with a learning disability in Wales is distinct from that other UK regions and international experience.

The literature review demonstrates an uncertain and unclear picture of adult protection practice, responses and decision-making. In a CLDT setting, in Wales, existing literature in relation to safeguarding is all but non-existent. Devolution across and affecting the United Kingdom makes this absence increasingly significant. Relevant for this research project is that the practitioners are registered nurses and registered social workers in a CLDT; professions that are consistent across CLDTs in Wales. It is unknown and under evidenced in the existing research how decisions about when an incident is considered to be abuse and a referral into the adult protection

process are made. This decision point is the focus of this study. The unique features of this study respond to the gaps in existing literature in the following areas:

- the changing context of adult safeguarding practice in Wales,
- focused upon staff supporting adults with a learning disability,
- awareness of nurse and social worker decision-making– recognising that they are core members of CLDTs in Wales,
- exploring influences upon the exercise of nurses and social workers' individual decision-making when recognising and responding to abuse.
- exploring the action that nurses and social workers take when they become aware of potential abuse.

Understanding how these contribute to adult safeguarding practice and decisions is essential to exploring the basis of this study: Responding to allegations of abuse: a qualitative study of the influences upon decisions made by nurses and social workers in CLDT's in Wales. The methodology for undertaking the study is explored next.

Chapter 3. Methodology

3.1 Introduction

This chapter addresses the methodological challenges and approaches that have influenced this project and the chosen research design. It presents the chosen methodology and methods to address the question – What influences decisions made by nurses and social workers in CLDTs in Wales when responding to potential allegations of abuse? The chapter then explores the available approaches and the relevance of the chosen qualitative approach. Other methodologies and methods are noted and acknowledged with discussion as to why these were rejected in this study. Grounded theory is identified as the chosen approach and is critically discussed with particular reference to the constructivist grounded theory method. The chosen constructivist grounded theory approach of situational analysis is then presented for use in this study. The research design is introduced including the methods used for this study, the recruitment of participants for the research project, ethical dilemmas, data gathering and data analysis.

3.2 Social research and qualitative/quantitative approaches

Within social sciences, qualitative and quantitative methodological approaches exist. Porter (1996) described four levels to understanding enquiry into human experience that can be summarised as ontology (concerned with what reality is), epistemology (concerned with what knowledge is), methodology (concerned with how reality can be understood), and methods (the way that the evidence is collected). Two major ontological positions or beliefs about existence are relevant to this study. The first of these is *objectivism,* an ontology associated with phenomena being external, predetermined and fixed. The opposite of this, Bryman (2012) describes is *constructivism* a view that the meanings applied to situations are continually subject to change and revision.

Each of these ontologies have different histories and associated epistemologies, different views of how data are deemed to be credible and how each makes sense of the world. The two main opposing epistemological

positions are *positivism* and *interpretivism.* Positivism is explained by Parahoo (2006) as a method that promotes the application of natural science methods and use of scientific, replicable tests. Conversely, *interpretivism* is the belief that people continuously make sense of the world around them. Parahoo (2006) and Shaw and Gould (2001) note that there is a long tradition of positivist and quantitative research in nursing and social work practice respectively, which has been reinforced by the demand for evidence or knowledge-based practice.

3.3 Quantitative methodology

Quantitative research has a history that is also predominant in medicine, a profession with which nursing has traditionally been aligned (Parahoo, 2006). Parahoo (2006) describes the positivist, quantitative approach as aligned with the natural sciences, concerned with stating a hypothesis and applying a predefined method of data collection and analysis which leads to the generation of findings presented in a numerical or statistical style.

Positivist, quantitative approaches remained largely unchallenged until the 1960s when post positivist authors emerged such as Garfinkel (Heritage, 1984). In the late 1960s, the development of symbolic interactionism was proposed by members of the Chicago School exploring the meanings of details and words used by participants within research (Blumer, 1969).

Social work research has a similar history to medicine in which a preference for quantitative data predominated with queries raised both within the profession and by related professionals as to the rigour of qualitative research (Shaw and Gould, 2001). Shaw and Gould (2001) acknowledge that there have been increased efforts to increase the authority of social work research and to establish a credible evidence base for practice, and thus, a quantitative methodology was preferred. Whilst Shaw and Gould (2001) offer a robust rebuttal of this view, the debate is a distraction to the main issue. Quantitative research cannot capture the human emotion, choices, priorities and dilemmas experienced in nursing and social work practice when making safeguarding decisions.

This understanding is key to this research study and makes a quantitative, positivist and objectivist approach inappropriate for this study. There is little existing evidence to build upon, no hypothesis to test, and no opportunity to quantify results – a quantitative and positivist methodology is therefore inappropriate for this study. The following sections explore the merits and weaknesses of the qualitative methods of ethnography, phenomenology and grounded theory, introducing grounded theory as the identified and preferred method for this study.

3.4 Qualitative methodology

A methodology is a means to access, gather, question and analyse information. A qualitative methodology needs to be able to accommodate complex data from underexplored situations which can prove challenging. Richards and Morse (2007) summarise that using qualitative methodology is a craft that should be practised, because complex human data demands such a response. Qualitative research will usually have fewer participants than quantitative data, as it relies upon a more in-depth consideration of a participant's experience and values personal description, known as the generation of rich data. The identified research approach for this study is qualitative methodology since the research question necessitates a broad, inductive method that requires the researcher to understand the meanings of the social actions described by participants. Induction presents the researcher with an opportunity to explore a tentative awareness or knowledge of a phenomenon, the data gathering and analysis is not necessarily predetermined or linear as deductive methods may require. It would be misleading to suggest that all methods associated to a qualitative methodology would produce the same levels of rich description and understanding of a participant's experience of making decisions about abuse. A number of qualitative approaches exist; these are now explored to consider appropriateness for use in this study.

3.4.1 Ethnography

Ethnography is a method in which the researcher lives amongst, or is immersed in, the culture and lives of the people that they are studying: it is a method that researches a phenomenon in its cultural context. The extent to which the role of the ethnographic researcher is known by participants may vary between projects and can be covert or overt. The researcher is, as Parahoo (2006) explains, the main instrument of data collection with information drawn from as wide a range of sources as legal and ethical boundaries will allow. The ethnographic method relies upon observing the phenomenon and recording it through a series of field notes, diaries, photographs and conversations.

Richards and Morse (2007) discuss that ethnography is usually undertaken by people who are not part of the same cultural group as the researcher stance is external to the group being studied. This view is, however, contested by Matthews and Ross (2010) who indicate that the researcher can be connected to the culture to be studied although they must be aware of this link. Entering someone's life and culture for the purpose of research can be a complex role with potential for conflict about purpose and loyalties (Hammersley and Atkinson, 2007). Where the additional identity of a practitioner–researcher is added, there is potential for further complications and conflict with the values of professional codes of conduct (including my own) (CCW, 2015).

Professional codes of conduct for health and social work practitioners require such values as honesty and trustworthiness, which may prove at odds with covert ethnography. Whilst the ethnographic method can yield thick, rich description, Bryman (2012) refers to the approach as unstructured with little indication as to when data gathering should end, with the potential that there is a need to return to the field later. The ethnographic approach has been discounted for this research project; the position of a practitioner as ethnographer is likely to be viewed with suspicion by practitioner participants. In addition, there are a number of ethical considerations as to the role of the ethnographer–researcher both in observing sensitive practice and where a covert role may be taken.

Ethnography has been rejected for this study. It is not a suitable approach to address the research question, as the decisions of nurses and social workers in a CLDT and the influences upon these decisions are not observable.

3.4.2 Phenomenology

Challenges to the positivist approach were made by the emergence of the qualitative method of phenomenology. Phenomenology, Richards and Morse (2007) explain is in the confusing position of being both a philosophy and an interpretivist research methodology. Whilst the method has evolved and adapted so that a number of versions of phenomenology now exist they share a broadly common foundation. The first interest of phenomenology is not to understand the participants' views or perceptions but to learn how it is to have *lived experience* of a situation (Parahoo, 2006). The second interest that Richards and Morse (2007) note is that in phenomenology human existence is in itself meaningful and interesting. This is because humans are always conscious of something – it is a condition of *being in the world*. In brief, phenomenology examines the human detail of experience – in detail. The requirement for such detail necessitates a high level of researcher reflection in order to understand the meanings that emerge from the data. This can mean that some phenomenological methods value or at least acknowledge the previous experience of the researcher (Flood, 2010) – who may also be a practitioner - whilst other variations require that a researcher suspend (or bracket) their pre-suppositions (Tuohy et al. 2013). The researcher stance in phenomenology is to understand how people understand the world through the filters of relationships to things, people, events and situations (Richards and Morse, 2007).

Phenomenological approaches usually include in-depth interviews that gather broad, rich description. Through a process of reflection, thematic analysis, writing and re-writing, the researcher interprets the meaning of the lived experience of the participant. There is an increasing use of phenomenology in nursing, social work and social sciences research (Shaw and Gould, 2001; Parahoo, 2006; Flood, 2010), as there is a natural congruence between wanting to understand a person's experience and understanding a patient's

experience of illness or treatment. However, in seeking to understand the motivations and priorities that nurses and social workers consider when making decisions about adult protection referrals, phenomenology is unlikely to be helpful. The lived experience of nurses and social workers who make decisions is not the matter to be researched and phenomenology is therefore not an appropriate method for this research study and is therefore rejected. Having identified that a qualitative method is required and explored, considered and discounted several qualitative approaches including ethnography and phenomenology an alternative qualitative method was chosen – grounded theory. The chosen approach for this study grounded theory is now discussed in detail.

3.4.3 Grounded Theory

Grounded theory is a method that starts from the ground (the data from participants) and works up in an inductive fashion, to make sense of what people say about their experiences, and convert this data into theoretical prepositions (Roberts and Taylor, 1998). Grounded theory is the chosen method for this research study, it is an appropriate choice where there is little existing knowledge and where a study asks questions exploring: 'what is going on here?' (Richards and Morse, 2007, p60). Consistent with an under – researched topic and being a practitioner – researcher (accepting the debates around this) grounded theory is 'methodologically restless' (Richards and Morse, 2007, p61). The theory that is later developed is grounded in the data of the study. In this research study, the participants' experience and practice of making decisions when they become aware of abuse is the starting point for the research. The chosen grounded theory approach values participant data, and generates theory grounded in participant experience.

Theories emerge out of, or are grounded in, the development of new theory (Parahoo, 2006) rather than responding to or testing a hypothesis as positivist/ deductive methods would. Richards and Morse (2007) describe that grounded theory has origins in the theory of symbolic interactionism (Mead, 1934,

Blumer, 1969) in which reality is a perspective negotiated between people that is constantly changing and being re- negotiated. This re-negotiation responds to cues (or symbols) for example in language and meanings of language to establish the reference points of the participant's experience. Developed from symbolic interactionism grounded theory builds upon the belief that:

> 'individuals find meaning in interaction, how they present and construct themselves and how they define situations together with other individuals' (Nilsson et al., 2012, p279).

Milliken and Schreiber (2012) add that not only is this a method for understanding how participants define themselves and their situation but that:

> '...symbolic interactionism provides some initial windows through which the researcher can view and think about the phenomena under study, thus expanding the breadth of theoretical codes available...' (p685).

Symbolic interactionism predates and influences grounded theory, it is an approach that Strauss, a founder of the grounded theory approach, was already familiar with through sociological research at the University of Chicago. It contributes to grounded theory the perspective that social reality is always in flux, requires detailed examination and that the researcher, alert to the subtleties of the participants' contribution, is part of this construction (Strauss and Corbin, 1998). Symbolic interactionism is central to the origins of grounded theory.

3.5 Origins of grounded theory

Glaser and Strauss developed grounded theory in their 1967 publication *'Discovery of Grounded Theory: Strategies for Qualitative Research'.* Grounded theory aimed to provide a structured, clear and systematic basis for qualitative research (Bryant and Charmaz, 2007). The origins of grounded theory are in the positivist roots of quantitative research. With a background as a quantitative researcher, Glaser argued that the grounded theory method

could also apply to quantitative enquiry and that using grounded theory could produce research outcomes with equal significance to those of the preferred quantitative approaches of the time (Bryant and Charmaz, 2007). Although a radical development and methodological departure, the qualitative grounded theory method both opposed quantitative approaches and copied it (Charmaz, 2006). The qualitative method of grounded theory developed by Glaser and Strauss (1967) started to move away from the positivist roots of social sciences research. Although qualitative methods, these positivist and post positivist methods predominately relied upon quantitative style data analysis methods and did not necessarily offer a means to capture the depth of human experience (Cohen and Manion, 1994). Charmaz (2006) acknowledges that the history of grounded theory is heavily influenced by the quantitative approaches, but offers that it became a major force in the early development of qualitative research.

Although Glaser and Strauss (1967) published together as joint founders of the method, the method later evolved and diverged. The respect for the approach and discipline of Glaser and Strauss (1967) contributed to grounded theory becoming a popular and accepted social science research method, and a respected bridge between positivist and more interpretivist methods of enquiry. The development of several variations of grounded theory have provided appropriate and evolving methods for a broad range of social science projects, however there are some grounded theory fundamentals that are shared between them.

3.5.1 Fundamentals of grounded theory

Using grounded theory is not necessarily a linear process, as the stages of data collection and analysis are not (always) separate, the phases overlap and happen simultaneously to achieve a sensitive, and stronger, analysis.

Grounded theory uses the researcher's reflection and ability to respond to, and build upon the emerging data - thereby participating in it, clarifying means and collaborating with participants in constructing the data. This is not to suggest that the researcher leads the participant in anyway but simply that they are

immersed in the data. Bryant & Charmaz, (2007) identify five common elements of all grounded theory, these are shown in table 3.1.

Theoretical sampling	A characteristic of sampling and recruiting participants in grounded theory research where the researcher seeks participants who can add to and further the data that has emerged.
Constant comparative analysis	Emerging data is collected, compared and analysed against each other and revisited to develop codes and examine concepts that appear to be arising.
Coding and categorisation of data	Grouping together and then refining the groupings of relevant participant data and sources from literature.
Memoing	A series of reflective notes made throughout the project to assist the researcher to explore the decisions made and the dilemmas presented by working with the data.
Theoretical Development	The production and presentation of new theory derived understanding and managing the data.

Table 3.1 Five core elements of grounded theory identified by Bryant and Charmaz (2007) with description of each stage.

Whilst there are core characteristics shared by all grounded theory approaches, they may have greater prominence in some models than others. These characteristics indicate the priorities of the authors of the method and their contribution to each grounded theory method. Table 3.2 summarises five grounded theory methods, demonstrating how the method has evolved and compares the priorities of each approach

	Glaser and Strauss	**Strauss and Corbin**	**Eaves Synthesis model**	**Charmaz**	**Clarke**
Model	Emergent	Full conceptual model	Synthesis technique	Constructionist	Situational Analysis
Ontology	Realism/objectivism	Symbolic interactionism/ interpretivism.	Interpretivism	Interpretivism (relativism)	Interpretivism
Epistemology	Positivist	Post – positivist	Post – positivist	Post – positivism (subjectivism)	Post- modern (constructionism)

Starting point	‘what’s happening here?’	‘what if..’	‘ to understand…’	To co-produce meaning with the participant.	What is happening in this situation?.
	Only after data has been gathered.	Some prior knowledge but not a full literature review. Second literature review required.		After initial data gathering. Acknowledges that a brief awareness/ preliminary review of literature may be required to secure funding or agreement for a project.	Literature review can take place at any stage. Further literature review/ theoretical sampling.
Literature review/theoretical sensitivity					

Data analysis	Line by line/ open coding Categories and subcategories. Core category Hypothesis checking.	• Open coding • Axial coding • Selective coding • Verification Core category	Line by line coding Reduce codes Create clusters Develop concepts Develop categories	• Initial coding • Focused coding. • Theoretical codes • Theoretical categories • Core category Concept/theory	Traditional grounded theory methods. Relational analysis leading to Situational maps

			Develop sub categories Links between categories Core category Develop and test theory		• Social words/arenas maps. • Positional map • Theoretical sampling. • Simplified maps Project maps

Table 3.2. Summary of grounded theory methods and characteristics.

Whilst there are shared elements common to all grounded theory methods, different approaches have developed, added, and emphasised different characteristics. These developments may be perceived as limitations to the grounded theory method, with critics suggesting that the existence of multiple approaches may be confusing (El Hussein et al, 2014), with the potential of being misinterpreted. Richards and Morse (2007) echo a similar concern, identifying that the title grounded theory is popularly and inappropriately applied to qualitative research that has not followed a grounded theory approach.

Researchers are implored by Richards and Morse (2007) to ensure that the true nature of grounded theory is understood to avoid confusion and inappropriate use of term. Tan (2010) identifies that the use of grounded theory has attracted debate and suspicion with concerns raised as to the rigour and robustness of the method. Like all research methodologies grounded theory has limitations. Some critics identify the lack of generalisability of findings (Misco, 2007) as a frustration. This lack of generalisability results from grounded theory being developed from specific situations that are not intended to be transferable to alternative situations, even if the approach is repeatable.

In addition, Bryant and Charmaz (2007) identify that the tendency of grounded theory methods to produce a large amount of data, which may be difficult to manage are a limitation. Equally, Bryant and Charmaz, (2007) add that the skill required in using grounded theory successfully, where there are no standard rules to follow, (for example the identification of categories) can be viewed as a disincentive.

Grounded theory, however, evolves to meet the challenges of social science research and responds to critics whilst maintaining the discipline required for credible research. This means that grounded theory requires the researcher to refuse to accept data at face value, seeking instead to understand participant responses, identifying key elements, and developing theory. Bryant and Charmaz' (2007) discuss that grounded theory can fail to recognise the embeddedness of the researcher and their considerable role in data construction and interpretation. This concern can be at least partially

overcome by acknowledging researcher- participant partnership in co-producing findings.

This participant co-production is particularly relevant to constructivist grounded theory. Constructivist grounded theory is an evolution of the traditional grounded theory method, it is also the chosen method for this research study which is now discussed.

3.5.2 Constructivist grounded theory

Further developing the grounded theory method, constructivist approaches explore the relationship between the researcher and participant and emphasise the creation of shared meanings in the data (Mills, Bonner and Francis 2006). Charmaz (2000, 2010) and Clarke (2003, 2005) are major authors in constructivist grounded theory. Constructivism denies the existence of objective reality as Charmaz (2000) writes;

> '…neither human realities nor real worlds are uni-dimensional.'…..and…'The constructivist approach assumes that what we take as real, as objective knowledge and truth is based upon our perspective' (p523)

Charmaz's view highlights that the constructivist grounded theory process is interpretive and subjective. The researcher must use their skills and resources to uncover what the participant really means by using flexibility, imagination, and personal reflection. In this way, in constructivist grounded theory meanings are understood and situated in the context of the participant (Mills, Bonner and Francis, 2006; Charmaz, 2010)

For Charmaz (2010), the constructivist researcher is a co-producer of the research with the participant. In taking this approach, the researcher is likely to need to be creative, responsive, reflective and empathetic in both the gathering and understanding of data. The role of the researcher as part of the co-production is at odds with Glaser's insistence that grounded theory should be emergent (1992), or the original position of Glaser and

Strauss (1967) that the researcher should occupy a detached role. The interpretivism that the constructivist grounded theory method requires is therefore a further development from the original grounded theory method. Charmaz (2010) is particularly concerned that constructivist grounded theory research should remain a disciplined craft and that research using this method should be able to demonstrate credibility, originality, resonance and usefulness.

Charmaz (2010) explains that she positions her constructivist grounded theory method between positivism and post modernism. Whilst Charmaz acknowledges the complexity of data gathered through co- production with participants, she describes it is a post–positivist method despite comment from Clarke (2003) and Mills (2007) that her method has post-modern elements. What Clarke (2003, 2005) aims to capture are the complexities and complications of post-modern life in the 21st century. This includes recognition of the post – modern assertion that there can be multiple truths and realities – rather than the one, single outcome that a positivist approach would seek/ acknowledge. Recognising the evolution of grounded theory further highlights the appropriateness of the chosen constructivist Situational Analysis method – which is now explored.

3.5.3 Situational Analysis – grounded theory after the post - modern turn

Situational Analysis focuses upon understanding a person's situation, the situation context and people, actions, interactions and relationships (Richards and Morse, 2007). Clarke (2005) recognises that there is a direct link between research and changing practice – the same motivation as prompted this study.

Clarke (2003) states:

> 'the reasons for doing research are often to decide how to intervene in a particular situation to improve conditions of some kind' (2003, p.302).

To pursue this, not only must the situation be understood but also the broader context in which the dilemma is situated. Understanding safeguarding decision - making presents an opportunity to intervene to improve current practice. The Situational Analysis method uses interviews, observations, literature and other sources to more fully explain complex situations (Clarke, 2005). Situational Analysis is less process orientated than other grounded theory methods and is not linear – the method is flexible but disciplined in order to understand the characteristics of a situation. As Clarke explains:

> 'the situation becomes the unit of analysis, and understanding its elements and their relationships is the primary goal' (2005, p.xxii).

Clarke (2003) proposes Situational Analysis as a method that offers a level of analysis of situations that other grounded theory methods do not. In particular, she challenges the detailed reductionist methods of Strauss and Corbin (1990). Clarke's method (2003, 2005) prompts the researcher to think deeply about, and analyse, the available data- a process that she describes as '*wallowing in data'* (Clarke, p85). A series of maps explores and demonstrates the relationships, priorities and links between data. The researcher then uses the maps drawing out those that endure as the most relevant. The three maps that Clarke (2005) offers are:

- **Situational maps**: these delineate major human, non-human and discursive elements that provoke analysis of the macro–level relationships between them.
- **Social networks/arenas maps**: these lay out the main collective actors, key non- human elements and areas of commitment and discourse in which they are involved. A meso-level interpretation of the situation.
- **Positional maps:** these lay out the main positions taken and not taken, particular axes of difference, and sites of inquiry about the situation. A micro level interpretation of the situation.

The relationships between the information on the maps will usually be of equivalent relevance until a final map is derived. A final map can be used to summarise the research and is referred to as a project map. This replaces the core category (the enduring major theme of the entire research study) of other grounded theory methods. Through a series of maps, Situational Analysis seeks to capture the complexity and conflicts of the research data but also to note the sites of silence – the unexplored dilemmas and gaps that are created. Clarke (2005) is concerned that traditionally in grounded theory work there has been a tendency towards inadequate reflexivity and reflection, and that this has been a weakness of such approaches. Clarke (2005) defends and values the origins of grounded theory in Situational Analysis and considers that her post–modern method is simply a development of grounded theory. Development and evolution Clarke (2005) suggests are touchstones of grounded theory and congruent with the foundation of grounded theory. Grounded theory is, after all, an approach originally developed to challenge the dominance and inappropriate application of natural sciences methodologies to social science situations.

Situational Analysis positions the researcher and the participants together in the creation of meanings in the data that is crucial to the constructivist grounded theory design of the study. This co–production values the participant, their experience and contribution, and it confirms the meanings and symbolism ascribed by the participant. It ensures that the researcher has understood the participant's priorities in order to analyse their data. Participants, their views and experience are at the heart of the design of this research project and the choice of Situational Analysis grounded theory.
This ensures that it is a relevant choice for this research study.

3.5.4 The choice of Situational Analysis in this research study

Situational Analysis (Clarke, 2005) is the chosen grounded theory method for this study. Situational Analysis focusses upon the participant's individual situation, their actions, interactions and the context in which they operate (Clarke, 2005). It is a personal and responsive approach that values the participant and their contribution. The researcher develops and changes the questions and prompts used in interviews to respond to emerging themes. The flexibility of this method means that whilst a researcher must be disciplined and able to explain their work, revisions and updates are not problematic to the method as when critically reflected upon, and acknowledged they may contribute to a stronger and clearer research product.

The use of situational, social worlds/arenas maps and positional maps which are integral to Situational Analysis prompt and allow deeper analysis of the data. The use of these maps - unique to Clarke's (2005) Situational Analysis – are explored later in this chapter. These maps illustrate the key themes emerging from the data and are intended to tease out, recognise and represent the complexities of post - modern life and experience. Clarke (2005) suggests that discussions of social worlds and their discourse have been both connected and overlooked. Using a series of maps to connect and explore the emerging ideas the data is opened up further and also illicit where sites of silence exist.

Situational Analysis (Clarke, 2005) and the recommended mapping techniques were chosen as they have the potential to highlight the complexity of how nurses and social workers within community learning disability teams make decisions about adult abuse. The choice of Situational Analysis completes the methodology choices for this study, the characteristics of my research are:

- *Ontology* – symbolic interactionism – individuals define their situation.

- *Epistemology* – constructivism – the world is socially constructed and constantly re-defined.
- *Methodology* – qualitative grounded theory – Situational Analysis.
- *Method* – Grounded theory: Situational Analysis interviews.

Having identified Situational Analysis as an appropriate method to address the research question, the design of the project is now presented.

3.6 Research design of this project

Situational Analysis is a flexible and responsive grounded theory approach that can accommodate several methods of data collection. In this study, literature and policy are included into the data gathering alongside the semistructured qualitative interviews. Alternative data collection techniques in situational analysis may include focus groups or shared discussion. As the participants are registered nurse and social work practitioners who hold a variety of roles within teams (including managers), this may have had the potential to affect the willingness of practitioners to participate. In addition, there was a possibility that in a group, practitioners would feel the need for their views to conform to each other.

For the sensitive topic of adult protection decision-making, a one to one interview was considered the most appropriate use of participant involvement. This recognises the sensitivity of the topic as well as giving participants the opportunity to speak at ease without other colleagues being aware of their comments. Appropriately recruiting participants for the study was essential to the project, both for the credibility of the research and to ensure that participants were aware of the commitments of taking part.

3.6.1 Sampling and participants

Participants for this study were registered social workers and registered learning disability nurses (or equivalent registration qualification, acknowledging that designation has changed over time) working within a CLDT. Ethical agreement was initially gained to recruit participants in five Local Authority areas that share the footprint of one health board. As the

numbers of staff and the composition of teams varied, it was difficult to anticipate the number of participants meeting the inclusion criteria and willing to take part. The grounded theory method and the requirement for data saturation also contributes to uncertainty when discussing numbers of potential participants. Bryman (2004) describes a sample for a research project as selection of a portion of a population. This section describes how the sample of participants in this study were identified and purposively sampled.

Nurses and social workers in five CLDTs were invited to take part in the project, with permission to approach staff agreed (further to ethical approval, discussed later in this chapter) in each of the five areas by the relevant Director of Social Service/ Head of Nursing. I attended meetings with nurse Team Managers of CLDTs within health boards to introduce the study and to facilitate meeting with individual nursing teams. An introductory meeting (usually during a team meeting) was held with staff in each of the five CLDTs (sometimes social workers or nurses only, sometimes both at a shared briefing) to give details of the project, time commitment required and the confidentiality/disclosure of the abuse process. With information packs available to all staff, members of the CLDT were able to contact me directly to arrange an interview and to raise any questions or queries that they may have.

A total of nine participants in three CLDTs chose to participate. In one CLDT, the Team Manager intervened to advise that she would only endorse senior staff participating and had identified one member of staff in the team who fulfilled this criterion. Whilst this presented a dilemma about whether to accept the one participant into the study, they met the inclusion criteria and became a participant. I was cautious that not accepting this participant could be considered as choosing participants, although the Team Manager had themselves influenced choices about participation.

All nine participants met the inclusion criteria (table 3.3) as outlined in the participant information sheet (Appendix 2).

Inclusion criteria
• Employed for one year in the CLDT by one of the participating health or social services agencies. • Registered nurse • Registered social worker.

Table 3.3. Inclusion criteria for participants.

The initial sample of nine interviews provided a valuable insight into the experiences of nurses and social workers with several early and conflicting experiences and themes emerging. With data saturation far from being achieved and no further participants identified, Team Managers were contacted again by email. This was intended to invite further members of the CLDT, who may have missed the first opportunity to participate to be included. No further participants were identified and it was agreed that it was necessary to extend the study. Ethical agreement (discussed later) was endorsed to extend the geographical area included, and to approach CLDT members in the neighbouring health board area and the corresponding Local Authority areas. The same pattern of health board management team attendance, team introductions and recruitment took place as in the original area. Directors of Social Services again endorsed approaching CLDT staff in each of the local authority areas, enabling contact with Team Managers. Team Managers coordinated attendance at team meetings, distribution of information packs and recruitment of participants. Following this extension of recruitment, a further 16 participants were identified. Data for nurses reached saturation after 9 interviews with data saturation for social workers taking considerably longer at 16 social work participants.

3.6.2 Demographic details of participants

Table 3.4 provides a summary of the research participants involved in this study. The details are derived from the demographic information sheets (Appendix 3) completed by participants. Some of these sheets were only

partially completed and two practitioners chose to give a verbal summary of their experience rather than complete the demographic information form.

Profession	Prior Experience (qualified)	Time in current post	Team Structure	Other VA roles	Identifier
Nurse (LD)	23 yrs	8 yrs	Health Co- located		N1
Nurse (LD)	10 years	7 years	Health Co -located		N2
Nurse (LD)	5 years	7 years	Health Co-located		N4
Nurse (LD)	11 years	12 years	Health Integrated		N5
Nurse (LD)	N/A	24 years	Health Co-located		N9
Nurse (LD)	30 years	3 years	Health Co-located		N13
Nurse (LD)	N/A	10 years	Health Co-located		N23
Nurse (LD)	N/A	8 years	Health Co-located		N24
Nurse (LD)	N/A	1 year	Health Co-located		N25
Social worker	N/A	21 years	LA Integrated	DLM	SW3
Social worker	N/A	10 years	LA Integrated		SW6
Social worker	33 years	11 years	LA Integrated		SW7

Social worker	7 Years	18 years	LA Integrated		SW8
Social worker	3 years	10 months	LA Integrated		SW10
Social worker	N/A	10 Years	LA Co-located		SW11
Social worker	N/A	3 years	LA Co-located		SW12
Social worker	N/A	8 years	LA Co-located	Investigator	SW14
Social worker	1 year	8 years	LA Integrated		SW15
Social worker	1 year	16 years	LA Co-located	Investigator Trainer JIVVA DLM	SW16
Social worker	2.5	5.5 years	LA Co-located	DLM	SW17
Social worker	1 year	10 years	LA Integrated		SW18
Social worker	N/A	3 years	LA Integrated		SW19
Social worker	N/A	2 years	LA Co- located		SW20
Social worker	N/A	20 years	LA Co-located		SW21
Social worker	N/A	5 years	LA Co- located		SW22

Table 3.4 Participant demographic information.

One nurse participant confirmed that they had been in post for over a year and met the inclusion criteria but chose not to give further details – they are therefore recorded as having one years' experience in this summary as the real figure is unknown. One participant had just 10 months' experience in the current team but had been attached to the team for over 12 months in transition from another post within the Local Authority. At the interview it was confirmed that the participant had three years' post qualification experience and was outside of their probation period. The inclusion of this participant was discussed with my supervisors and considered appropriate to include the practitioner, as she had been attached to the team for the inclusion criteria period. It was also discussed in supervision that in terms of responsible use of participant's time and contribution inclusion was appropriate. The prior experience identification in the demographic information was clarified to represent time as a professional with the current registration. The gender of participants has not been included in this summary of demographic information to avoid potential for any (mis) identification of participants. Three of the 25 participants were male.

Of the 25 participants, three social workers identified that they also had a management role as either Senior Practitioner/Assistant Team Manager or Team Manager. Two of the nurse participants identified that they had a supervisory responsibility as part of their job role. The demographic information is *as reported by the participant* this includes that participants in the same CLDT identified that they worked in a different team configuration to each other - co-located and integrated. Whether this is a lack of clarity in the participant demographic information or whether participants were genuinely unclear about team configuration is unknown. As recognised earlier, the history of the registration of learning disability nurses identified that there were participants who identified themselves as a Registered Nurse Learning Disability (RNLD) or Registered Nurse Mental Handicap (RNMH). In table 3.4, all nurses with these registrations are included as Registered Nurse Learning Disability (LD) the current recognised registration. Two participants – one social worker and one

nurse (LD) also held a qualification as a Registered General Nurse (RGN) although both had been qualified in their current work roles for at least 15 years.

Five participants (all Local Authority) identified that they had additional roles within the adult protection process. Three people identified that they fulfilled the role of Designated Lead Manager (DLM) as defined in the 2010 guidance (SSIA, 2010). Two participants also held the role of investigating officer under the 2010 SSIA guidance and one of these was involved in the adult protection training of local authority staff. One of these participants also identified that they had trained to undertake Joint Investigation of Vulnerable Adult (JIVA) training to interview vulnerable adults with the police.

Recruitment to the project was challenging for several reasons. The low numbers of participants in the original area was problematic; feedback identified that practitioners felt unable to commit to an interview as workloads limited availability. In another team, an office re-location and colocation between health and social care was identified as barrier to availability. A second reason identified across some CLDTs was high levels of sickness that had reduced the numbers of staff with remaining staff providing duty cover.

The sensitive nature of adult protection practice is a third suggestion of why CLDT members may have been deterred from participating; potentially for fear of what might be perceived as a *wrong* answer emerging. Lastly, it became clear during research interviews that some participants were unclear that not having a formal role in the adult protection process as defined by the All – Wales guidelines (SSIA, 2010) did not mean that they were not part of the safeguarding process. Four participants described that they had no experience of adult protection practice although all four identified that they had made a disclosure of abuse to a manager or completed an adult protection referral form. It was confirmed with these participants that this very experience or dilemma was the subject of the

research, whilst acknowledging that they may not have realised this previously. With participation confirmed and consent to participate clarified research interviews were commenced.

3.6.3 Data collection: interviews

The Situational Analysis method does not prescribe any particular format – or that interviews should be the preferred method. For this research study interviews are an appropriate choice of data collection method; both to provide a safe environment for views to shared and to be able to respond quickly to cues and prompts in the participant's information. Pope and Mays
(2006) discuss that semi–structured interviews offer flexibility to respond to a situation whilst having a series of prompts to structure the data gathering. They argue that the use of unstructured interviews is virtually unknown (and impractical) as the researcher needs to be alert to, and able to respond to the key themes of interest. Unstructured interviews may risk wasting the time of participants in reaching the key areas of interest or building upon themes that have emerged from previous interviews. Equally, highly structured interviews are assessed by Pope and Mays (2006) as unlikely to yield rich data, especially in grounded theory where purposeful (initial sampling) and theoretical sampling (more focused sampling) of participants is a feature. By necessity, interviews based on theoretical sampling will need to alter to respond to the themes arising with one interview building upon the other - a highly structured approach is therefore unlikely to helpful. As interviews and associated grounded theory coding develops, theoretical sampling is then used to focus upon and identify the next participants or relevant source. Theoretical sampling, Clarke (2005), offers is the identification and incorporation of data sources (persons or things) that can respond to theoretically interesting elements of the emerging data.

By adjusting the structure for each interview in response to the data arising from the previous one the researcher is both connected with, and remains *grounded* in, the data. The original, initial interview guide sheet used in this project is available in Appendix 1. During the interviews, I was alert to the need to be aware of the language used and to confirm the meanings of the

words used with the participants. This acknowledges the influence of symbolic interactionism and the significance of the use of participants' language and meaning ascribed to language by them.

The semi–structured interview fits the Situational Analysis approach, providing an opportunity to respond to and explore responses. The use of a semistructured interview ensures that participants' time is respected and well used, focussing upon key areas of interest and not spent gathering sensitive but extraneous information. The use of the semi-structured interviews is not to suggest that the interviewer uses the same prompts with each participant or group of participants; rather that as the data evolves, so do the prompts that the researcher introduces to the interview.

The first ten interviews followed the same pattern as outlined in the interview guide sheet (Appendix 1). From interviews 11 to 18, the emerging themes were given greater prominence and integrated into the interview. The focus of interviews 19 to 25 was steered towards the emerging themes predominating the conversation, being mindful not to overlook any new ideas. I was aware that with emerging themes on my mind, there was a potential that focused questions became leading questions, and was cautious to avoid this. The last five interviews confirmed that data saturation had been achieved, with the transcription of interviews demonstrating how interviews evolved. Recognising that there are different numbers of social workers to nurses (16:9) in this study, it is worth noting that the interviews of nurses and social workers were interspersed. This ensured that emerging themes and ideas that suggested data saturation were explored with both professional groups. Data saturation was confirmed through discussion and scrutiny in supervision using developing data analysis and checking of codes derived from transcripts of interviews. The data is gathered acknowledging theoretical sensitivity through the interaction or co- production of the researcher and participant.

Haar, Norlyk and Hall (2014) discuss that when undertaking interviews the researcher–participant relationship relies upon a close relationship, trust

and confidentiality. They continue that the relationship has the potential for an imbalance of power as the researcher poses the research questions, decides the interview process and procedure and dominates the interview. Whilst the researcher is a tool of the research, it is necessary to be mindful that as a practitioner–researcher there are some additional considerations that are relevant to this research study. Dickson- Swift et al. (2006) acknowledge the differences and similarities between the research and therapeutic (or practice) interview, whilst recognising that some skills such as empathy, listening skills and rapport required in both situations. Ahern (2012) highlights that trust between researcher and participant in a series of interviews with professional staff was viewed as critical to taking part. Ahern (2012) identified that participants in her study felt at ease to participate because of a personal or professional characteristics of the researcher interviewing. Whether I was seen by social workers as a peer and whether that link encouraged recruitment is unclear. It is certainly an association that was made clear to participants, along with the expectations attached to this, but not intended as an incentive or disincentive in recruiting participants. Whilst some participants may appreciate the opportunity to discuss the topic of research (Rossetto, 2014), and it may prompt personal reflection upon adult protection practice, it is not the intention of the research interview. Birch and Miller (2000) raise concerns about the consideration of a research interview as in any way therapeutic. They summarise that in a research interview the participant is helping the researcher by providing information whereas in a therapeutic or practice interview, the interviewer is listening to the person with an intention of offering support.

Using interviews as a data gathering technique highlights some practice challenges. Lee-

Treweek and Linkogle (2000) reflect upon the additional

'danger' associated with being a practitioner – researcher. In particular, they recognise the need to maintain a research practice that is consistent

with the ethical requirements of both professional and research practice which are discussed later in the chapter.

Understanding the differences of the practitioner/ researcher role is necessary for the safety and wellbeing of researcher and participants. The participant information leaflet (see Appendix 2) outlined that I am a practising social worker with responsibilities to raise incidents of potential abuse in the event that they were disclosed. Staff were aware that in these circumstances their practice would be directed to their manager and this could have been viewed as a disincentive to participation. As a personal risk, combining the roles of researcher with practitioner responsibilities carried additional commitment to be alert to abuse raised by participants and to ensure that action was taken.

3.6.4 Undertaking interviews for this study

Interviews were scheduled during the working day at the place of work of participants. In each venue a private room was available and I managed appointments directly. Some participants had discussed their agreement to take part in the research and offered to coordinate bookings for research interviews throughout the day. In order to respect privacy of participants this offer was not accepted. The opportunity to be interviewed at a neutral venue at the University of South Wales was not taken up by any participant. This was identified by a number of CLDT members as related to time commitments and to reduce traveling. Whilst participants had my contact details and those of the supervisory team to raise any concerns or queries about the project it had been agreed at ethical approval stage that dilemmas raised by the adult protection content were to be directed to the staff members' own professional support.

One of the CLDTs involved in the research involves members of staff sharing the same employer as myself. McDermid et al. (2014) discuss the dilemma that researchers may experience if they are involving peers in their research. Whilst the relationship is more distant than a peer relationship it requires acknowledgement. McDermid et al. (2014) recommend that when including

colleague participants ensuring clear boundaries, maintaining trust and confidentiality and being mindful of conflicting roles are strategies to maintaining both good research discipline and collegial relations. The potential for a conflict in roles was recognised and discussed in supervision, including whether it was appropriate to recruit participants from this team. Through supervision it was agreed as appropriate with interviews taking place only on days for which annual leave had been booked. At the start of these interviews, it was clarified that the research project was not part of an employment role and participation was entirely optional.

In the early research interviews, some comments identifying organisational tensions in the adult protection process were evident and strong opinions were raised about the purpose of the adult protection process and the roles and responsibilities of staff within it. Steering interviews back to the topics indicated on the interview guide sheet (Appendix 1) rapidly developed as a skill, as did moving the conversation onto less emotive topics or separating prompts to reduce discomfort around one topic.

The interviews took place between August 2012 and November 2013. In total 25 in-depth one to one interviews were undertaken, recorded, and transcribed in preparation for further analysis. The shortest of these interviews was 40 minutes and the longest 55 minutes, with 30 hours of recordings transcribed in total. Each interview followed the same pattern: an introduction, a series of semi-structured questions, concluding the interview and confirming the welfare of the participant. My interview schedule and recruitment progress was discussed in each supervision meeting, along with any concerns or comments that that had been provoked by the content of interviews. In addition, I took the opportunity to contact the supervision team by email after a number of interviews to discuss my reaction to the interview, noting feelings of both anxiety and excitement which were also committed to memo writing. Memo writing in this project also incorporates field notes as field notes tended to contain no

more than a few keywords to avoid breaking concentration from the participant.

Whilst some participants were unsure of what to expect, most were confident to participate or had awareness of research interviews as participant, research user or researcher. In one interview a participant showed signs of anxiety/distress so the interview was paused with the option to stop although the participant chose to continue. The opportunity for the participant to discuss their experience with their supervisor was also raised as it was possible that they were not aware of the strength of their emotion linked to their experience. McDermid et al. (2014) recognise that managing this trust and rapport is crucial to the success of a research interview. My approach was intended to be interested, open, and friendly whilst being mindful that the role of researcher is not a friendship (DicksonSwift, 2008, McDermid, 2014). My experience as a practitioner was helpful in that I had an awareness of some of the practice issues described by participants without it causing me distress as it might a non-practitioner researcher. The opportunity to discuss the interview experience with my supervision team was available throughout data gathering.

Towards the end of each interview I directed the interview onto neutral topics of conversation usually returning to the person's experience and employment. I was cautious throughout the interviews that I should be viewed as neither expert in adult protection or judge of practice as suggested as possible by McDermid et al. (2014). Consistent with the situational grounded theory method where information represents a moment in time (Breckenridge and Jones, 2009) the interviews were transcribed but not sent to, or re-read or amended by participants. Referred to as member checking this was not considered compatible with the immediate constant comparative analysis of the grounded theory method

3.6.5 Transcription and the storage of data

All of the interviews were transcribed, subsequently anonymised and stored within the qualitative data computer software programme Nvivo 10. Acknowledging my specific learning difficulties, the transcription was undertaken by a third party. This was not without careful consideration as Oliver, Serovich and Mason (2005) describe that transcription, often seen as a behind-the-scenes task is an essential step in understanding and reflecting upon the interview data. The interview data contained sensitive and identifiable information and for this reason support staff within the University of South Wales, subject to the same confidentiality as myself, were identified by student services to undertake the work. All data for this project has been password protected at all times and stored on a computer using data encryption software and double password protection. The sound files were transferred to student services by secure online transfer, protected by password log in.

The allocation of work by student services to a number of different transcribers required discussion to ensure that the University of South Wales transcription conventions were used and that style and presentation were consistent. The interviewer and participant voices were transcribed in different colours for ease of reading. Despite the intention of achieving consistency, the transcriptions varied in accuracy and presentation these remain evident in the details stored in Nvivo. A further difference with third party transcribed interviews is that where an interview incorporates a conversation that is not directly relevant these are transcribed also as no interviewer-transcriber discretion can be exercised. The allocation of staff to these tasks by student services was discussed in supervision, considering whether their experience made them best placed for this task.

A summary of the terms and abbreviations were provided to the transcribers to ensure accuracy and I requested that the interviews were transcribed word for word including notification of pauses. Dickson-Swift et al. (2008) acknowledge that transcribing an interview can be an emotional

experience and I was aware that for a third party transcribing this information there was a possibility that the content could be difficult. Warr (2004) is alert to transcribers absorbing the sensitive details of the research and that this needs to be considered when commissioning third party transcription.

To ensure intimacy with the interviews I listened to the interviews before they went to the transcriber. I also noted tone, pauses and silences and looked for the meanings in the data that needed to be considered. These considerations were noted in a series of memos. When the transcripts were returned I listened back to the interview with the transcript in front of me, making adjustments or corrections at the same time and removing any remaining identifiable information. This process enabled the personal reflection that Oliver, Serovich and Mason (2005) consider essential and is an essential characteristic of constructivist grounded theory.

The transcription stage was less straightforward than I had envisaged, I felt proprietorial of the data and disloyal to it and participants by it being transcribed by a third party. As I reflected on the views of Jupp (2006) that transcription is essential to understanding the emerging data I was reassured that he believes that the effects of not personally transcribing interviews can be mitigated if not eliminated Whilst waiting for the interviews to be returned, transcribed (an average of seven days) I was still able to listen to the interview and continue memoing. This enabled me to remain alert to the emerging themes to be integrated into the next interviews. Listening back to interviews and updating the returned transcript was time consuming. With each transcriber working in a slightly different style absolute consistency was not necessarily achieved, even after corrections. These transcripts were then used for coding and data analysis. General principles of the grounded theory and Situational Analysis data analysis process are outlined next and are followed, later, by explanation of how these principles were applied to this study.

3.6.6 Data analysis: principles of data analysis grounded theory - coding

Data analysis is a means of understanding and making sense of data, working with it and organising it to assist the development of new theory. In the 1967 text (Glaser and Strauss, 1967) the approach to data analysis is very loosely defined. Prompted by this absence of detail Strauss and Corbin published further texts to offer more detail (1990, 1998). Coding participant data in order to analyse it is identified as a consistent feature of traditional grounded theory methods, although the details of these may vary between methods. Coding data contributes towards data analysis.

Clarke (2005) describes that in the grounded theory method the researcher attaches a series of temporary labels - or codes - to particular data that appear significant at that point in time. Coding promotes a close analysis of data as the researcher analyses and codes each line of an interview (Charmaz, 2000), this can allow for some 'unruly' elements to be discarded and others retained (Bryant and Charmaz, 2007). Coding can be considered to be a transitional process in which the researcher asks questions of the data such as 'what's going on here?' (Glaser and Strauss, 1967; Glaser, 1978; Richards and Morse, 2007). Richards and Morse, (2007) continue that there are three main grounded theory coding phases: *open coding* – an initial look at the data, *axial coding* – a focus around a concept; and *selective coding* that focuses upon one category at a time.

Strauss and Corbin's (1990, 1998) approach to coding is far more structured than previous grounded theory methods with the process concluding with selective sampling and coding to address any gaps in the data. Glaser (1992) criticised Strauss and Corbin's modification to the grounded theory methodology arguing that it moved away from grounded theory and was instead a full conceptual description model with coding so prescribed that data is forced. Further criticisms included being unnecessarily rigid and that both theoretical sensitivity and theoretical

sampling of participants were accepted, a clear post positivist departure from the original work of Glaser and Strauss (1967). The acknowledgement by Strauss and Corbin (1990, 1998) of theoretical sensitivity requires that a researcher at least acknowledge the presence of subjectivity in this methodology. In Glaser's method (1992), initial data analysis using coding to answer the question '*what do we have here?'* assists the data to move from the researcher's initial thoughts to be part of their thinking and on towards *saturation* when conclusions are offered.

The complexities and conflicts of grounded theory have had the potential to detract from what the methodology can offer (Eaves, 2001; Clarke, 2003). Eaves (2001) discusses the need for an open conversation to understand the place of coding in grounded theory projects and suggests that the technical complexity of the coding may be perceived as a weakness. Coding is not without its challenges and potential pitfalls, Richards and Morse (2007) advise that coding should not be viewed as an administrative task. Coding, they explain is central to data analysis; and data analysis should never be considered routine or mundane.

The synthesis technique that Eaves (2001) proposes draws upon the work of established grounded theorists emphasising that data analysis is not necessarily a linear process. In the synthesis method that she proposes, Eaves (2001) highlights (or borrows) the analytical steps of existing grounded theory and organises them into a more flexible technique. Charmaz (2010) advocates that constructivist researchers use open/ initial coding – line by line analysis of data and use of the participants' own views and words (in vivo codes). Constructivist grounded theory requires that the researcher asks analytical questions of the data through the use of codes to break apart and understand the data, albeit in a more straightforward manner than that proposed by Strauss and Corbin (1990). To assist the grounded theory researcher to understand and to be connected to the data a series of memos are completed – a characteristic that endures across all grounded theory methods.

3.6.7 Data analysis: memos

Memos are a feature in the grounded theory method, that are intended to increase reflexivity and to challenge/aid the development of codes. Loyal to the grounded theory method constructivist approaches require the use of memos to explore the emerging data and theoretical sampling to examine gaps in data and data saturation. For Clarke (2005) memo writing and coding are intertwined and both assist the researcher to understand the data.

Memos are notes written as the researcher reflects upon their coded data thinking about new opportunities to heighten theoretical sensitivity to the issue in question (Birks, Chapman and Francis, 2008). Hoare, Mills and Francis (2012) reflect that the memos may appear mundane or ordinary at the point in time in which they are written, but may later evidence a shift in thinking and clarify the priority of codes identified. Clarke (2005) explains that memos are usually partial, tentative and full of further questions that in turn allow the researcher to explore and make sense of the participant's experience (Glaser and Strauss, 1967; Glaser 1978). Memoing and coding are not necessarily part of a linear process, as it is possible (if not likely) that in exploring the data the researcher will need to return to the original data or to undertake more interviews. Data gathering and data analysis in grounded theory stops when theoretical saturation is reached and no further themes or ideas emerge.

Codes that endure or continue to be relevant/present in the project data are likely to become *categories* although the process for achieving this is challenging and disciplined (Walliman, 2005).

3.6.8 Data analysis: categories

In forming categories coding becomes about linking data rather than merely labelling it (Richards and Morse, 2007). These categories then become the main focus of the research project and contribute to the generation of theory. Frequently in grounded theory there will be a core category – a

major theme identified and derived from the other categories. Glaser (1978) describes that in grounded theory the generation of theory takes place around the core category. Working towards and eventually identifying a core category, Glaser

(1978) adds, keeps the grounded theory 'effort' relevant and workable – possibly, because it provides an identifiable end or outcome to the research. The core category endures throughout the data analysis, it is abstracted from the data but remains relevant to the experiences described by participants and grounded in the project data. Having identified the common or shared features of grounded theory the following section discusses how Situational Analysis develops traditional methods, making it an appropriate choice for this study.

3.7 Data analysis: Situational Analysis

Gathering and coding participant data is an early and essential research activity in Situational Analysis. It is supplemented and supported by extensions to the grounded theory method aimed at deeper analysis. To support this deeper analysis, Clarke (2005) proposes using a series of maps. Mapping, she advises is a means of prompting the researcher to explore and understand this 'situatedness'. Clarke (2005) identifies that analysis is required at micro, meso and macro levels to achieve this understanding. Whilst human interaction and experience changes over time and the lines between levels can be porous, an introduction to the three levels is necessary.

- **Micro–level**: the local, personal or individual level at which a participant experiences the dilemma. Positional maps are an example in this study of micro-level situational mapping.

- **Meso–level**: influences upon the individual that may not be identified as immediately relevant or connected to the dilemma but exist and contribute to the broader environment in which participants operate. Exploration of the meso level is strongly connected to social worlds mapping.

- **Macro–level**: the wider context which influences dilemmas and the experience of participants (whether or not they are aware of it).

Clarke (2005) is clear that elements that appear important may emerge and fade in relevance during data analysis, and that this is to be expected as part of becoming familiar with the situation being analysed. Figure 3.1 illustrates how this deeper analysis is achieved using Situational Analysis. The colour coding indicates elements of traditional grounded theory (green), the position of Situational Analysis maps (purple), and the areas for consideration that Clarke (2005) introduces in Situational Analysis (blue).

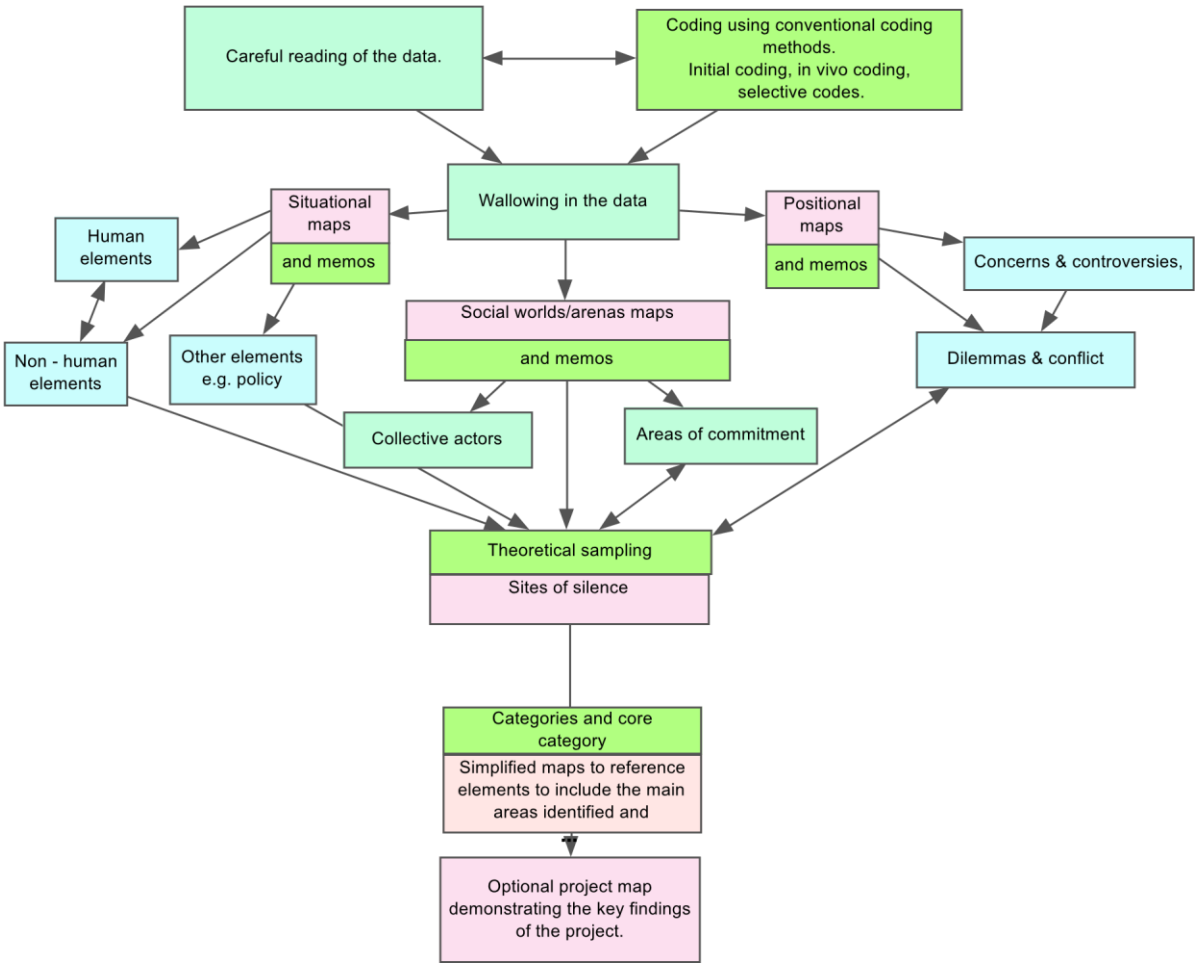


Figure 3.1 Situational Analysis data analysis process.

The significant addition in Situational Analysis to other grounded theory methods is the use of maps to tease out the details and complexity of the situations that participant's experience. Greater detail is now provided to explain how the different maps used in Situational Analysis contribute to understanding and analysing the data.

3.7.1 Situational mapping

The methodology section of this project acknowledges that Clarke (2005) is clear that situational maps should demonstrate the major human and nonhuman elements of the situation researched. These maps can take a number of formats; a 'messy version' of the situational map is advocated by Clarke (2005) as a representation of early ideas and thoughts some of which became more or less significant over time as the analysis continues. Later a tidier or ordered situational map can be used to indicate the connections, relations and relationships between emerging ideas. As a framework for analysing emerging data, an ordered situational map includes people and the roles that they hold (human elements) and recognises the context in which they operate (the non-human elements.

Returning to and updating the messy situational map throughout initial coding (and re-coding) an ordered version was completed (presented in next chapter) containing the elements that appeared most obviously relevant to my research study. The ordered situational maps constitute a framework or to use the phrase of Milliken and Schreiber (2012); a window through which further analytical thinking can take place. What the ordered situational map does not (and is not intended) to acknowledge is the relationship between each or any of these elements. Clarke (2005) suggests that questions should be asked of the elements in the situational map to explore or recognise the relations between them. Identifying these links has been supported by re-visiting data, memoing and personal reflection as well as discussion in supervision.

3.7.2 Relational mapping

Whilst remaining a form of situational map the development of a relational map is an early attempt in getting to know the data to *'help the analyst to decide which stories – which relations to pursue'* (Clarke, 2005, p102). With the links or relations identified, lines of connection were created on the situational map. The relationships that endured are then transferred into relational maps of their own. Whilst relational maps remain a work in progress throughout the project, they both challenged and provided evidence of the evolution of ideas. This is especially useful where the emerging themes have the potential to be in conflict with existing literature, practice or policy direction. A relational map is provided in each of the following chapters discussing the initial themes arising from the data. Each of these relational maps acknowledges and is derived and has evolved from the human and non–human elements of the ordered situational map.

Clarke (2005) is keen that Situational Analysis acknowledges the presence of a number of positions taken by participants and considers this to be democratising – a representation and valuing of diverse views. This broad, inclusive view extends not just to the views expressed by participants, but recognises that their experience and views are situated in a wider situational and organisational context. Clarke's (2005) second type of map–social world mapping is a recognition and response to this complexity.

3.7.3 Social world mapping

Referring to macro, meso and micro levels of mapping and analysis; social worlds map for Clarke (2005) are the middle or meso level. Den Outer, Handley and Price (2012) describe this meso level as:

> '…analysis where the researcher maps the categories that make up the social world of the actors (as perceived by them and articulated to the interpreting researcher) at the heart of the inquiry and determines their commitments, relations, and sites of action' (p3)

Whilst much of the search in this study is to understand meaning has centred upon the individual–social worlds look at collectives and acknowledge how individuals as well as organisations structure themselves. These social worlds recognise the presence of power and influence and how these interact. This includes where there are sites of commitment, demonstrated by them touching on the map or an inter/intra – dependence in practice. These boundaries are described by Clarke (2005) as porous, or perhaps more appropriately potentially porous. There are also overlaps as some actors and elements that exist in more than one world. Clarke (2005) advocates that social worlds maps do not necessitate significant editing or need to be a refined product; their main purpose is to acknowledge a number of potential influences or priorities. Neither does Clarke (2005) expect or anticipate that all actors who appear in a social world be involved at all times. The prominence of each these actors of these is likely to change and vary depending upon the situation being explored and whether the actor is involved in the social arena at that time. Where an actor does not feature but might otherwise be expected to, for example through exposure to literature, this may be a site of silence. As a result, some of the actors that feature on a social worlds map may not have been directly identified by participants as relevant but was otherwise identified as significant.

Social worlds maps are part of meso or middle level analysis, positional maps are a means of analysing and understanding more personal, microlevel considerations. Greater detail is provided by the use of positional maps.

3.7.4 Positional mapping

Positional maps represent different views, positions taken and sites of contradiction or agreement. Clarke (2005) identifies that they lay out the main positions taken and not taken. In particular, axes of difference, agreement and sites of silence about the situation emerge through this micro-level analysis. As a data analysis tool, positional maps clarify and

challenge the emerging priorities and to provoke greater discussion. Clarke (2005) acknowledges these as essential to exploring the data and understanding the emerging theoretical storyline. Figure 3.2 is an example of an abstract positional map, one map illustrates just one theme with the positions placed indicating greater or lesser agreement with the statement on the axes.

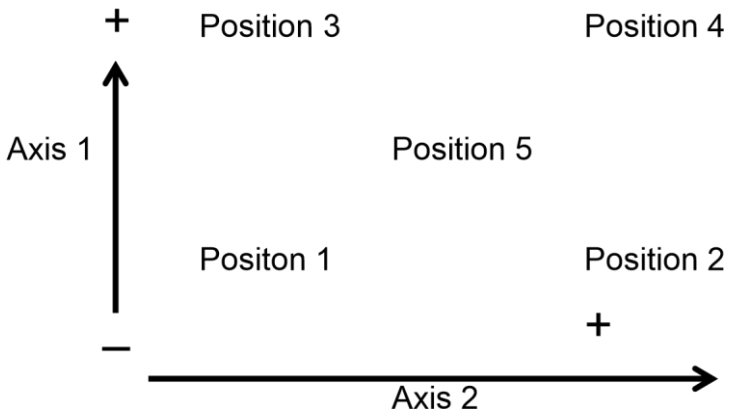


Figure 3.2 An abstract positional map

A strength of positional mapping is, as Clarke (2005) advises, that the researcher can explore the 'more versus less' (p128) of data first experienced at coding.

3.7.5 Project maps

Clarke (2005) identifies a final map that is optional in Situational Analysis, but where it is used, replaces the core category associated with traditional grounded theory methods. Project maps are specific to the research projects that they represent, for this reason Clarke (2005) does not and cannot offer an abstract project map. Instead, she suggests that as any project map is essentially relational that and that these relationships need to be clear. As a final product of research, it is a visual presentation of the headlines identified by the research undertaken. Having explored social research methodologies, grounded theory methods and in particular the

Situational Analysis method the application of these to the design of my PhD research is now outlined.

3.7.6 Data analysis: use of coding in this Situational Analysis study

Clarke (2005) advocates use of traditional grounded theory coding techniques- where the researcher codes data and writes memos in order to understand it. Mapping, in Situational Analysis, accompanies and compliments this process. Whilst the data analysis method of coding may appear to have become a shorthand for understanding qualitative information (Parahoo, 2008), the place of coding in grounded theory is central. Recognising that, Clarke (2005) advises that coding should take place using conventional grounded theory coding methods, little practical guidance or preference for this stage is expressed by her. I followed Charmaz's (2010) advice that coding should be short, simple and precise enabling me to move through the data quickly. This did present a difficulty that in the early coding of interviews I coded too little of the transcript which compromised understanding and made it necessary to return to the codes and transcripts to evidence the data associated to the code. The use of QSR Nvivo (9) assisted this and made returning to the data straightforward. Houghton et al (2015) advocate the use of Nvivo for rigorous, auditable data management at all stages of coding as well as assisting the researcher to manage the data.

Using Nvivo I was able to move between initial codes to develop selective codes and categories and to follow/ retrace the decisions that I had made, making memos as these were amended. Table 3.5 clarifies the stages of analysis that I followed. 157 initial codes were identified (excluding 7 codes created in error), these were refined through messy situational maps and focused coding to 100 codes. Table 3.6 is an example of how some of these initial codes were consolidated.

Absorbed by the coding process and understanding my data, once initial codes were identified I used paper copies of the interview transcripts and coding excerpts to cluster, adjust and to re-cluster these into the final selective codes and later into categories. Nvivo was then used to record these and to provide an auditable permanent account of the steps taken. Using both Nvivo and paper copies enabled me to be close to the data. The identified initial codes, selective codes and categories were verified and discussed in supervision as appropriate when independent coding was compared and Nvivo codes were compared without prior discussion.

Stage 1	Initial/open codes	Initial codes define what the researcher identifies in the data, picks up general terms and ideas. These are usually short, precise and comparative (Charmaz, 2010). Undertaken by use of examining paper copies of transcripts and uses of QSR Nvivo software.
Stage 1	Nvivo codes	Transcripts of interviews were stored in the QSR Nvivo software. This computer package is a database to assist with the management of codes and categories. The software aided the auditability of changes and provided an overview of developments.
Stage 1	Axial codes	Designed to join up into a larger cluster the initial/open codes true to Strauss and Corbin's (1998) coding paradigm. These are a bridge between the initial codes and more refined selective codes.
Stage 2	Selective codes	Careful consideration of the initial and axial codes to identify codes that share concepts and can be categorised together to make more sense of the data.

		Dey (1993) refers to selective codes as the *'analytical equivalent of putting mortar between the building blocks'* (p48)
Stage 2	Situational maps and social worlds map	Messy, working versions of situational maps considering the relationships and potential relationships emerging from the data.
Stage 3	Categories and core category	Themes generated by the data – the grouping together of relevant codes to form categories indicating relationships between them that are enduring and relevant. The core category is the category that Strauss (1987) identifies as connected to all other categories, frequently occurring in the data, whose identification is clear, logical and consistent and can explain the main point made by the data.
Stage 3	Project map	A visual representation of the 'big news' of the project.

Table 3.5. A table of coding approaches used in this research project.

Initial codes	Selective Codes
Difference, disagreement, agreement (lack of), perspective (differing).	Conflict
Shared, blame, collective responsibility, colleagues.	Accountability

Table 3.6. Example of consolidation of codes from initial codes to selective codes.

The development of selective codes and considering codes on paper assisted the grouping of information and the identification of five broader categories with which relevant codes could be associated. Handling data

in this way constitutes '*wallowing in the data'* which Clarke (2005, p85) considers essential to remaining close and open to the data.

3.7.7 Early emerging themes: responding to allegations of abuse

This chapter has discussed the chosen research methodology and introduced Clarke's Situational Analysis (2005) as a suitable method for exploring the influences upon the decision- nurses and social workers in a CLDT in relation to abuse. The use of semi–structured interviews as a suitable approach to gain thick, rich details from participants was identified as appropriate. Using interviews as the identified data collection method employing the techniques identified in this chapter thick, rich data emerged. As the interviews began to saturate around a number of key themes these were tested out and challenged through coding, mapping, memoing and revisiting literature. The themes that endured were identified as core categories with one core category later emerging.

Categories	Core category
• • The official line • Expectation and perception • Non vulnerable adult process options • Confidence and competence	**The tipping point**

Table 3.7 Categories and core category

Undertaking research with participants in the sensitive subject of adult abuse and decision-making necessitates a number of ethical considerations to ensure that participants and data are appropriately managed. Ethical considerations are now discussed followed by

commentary on how academic rigour has been achieved in this research study.

3.8 Ethical considerations

Dickson-Swift, James and Liamputtong (2008) suggest that some subject areas are considered to be sensitive for research, notably death, violence and abuse. Acknowledging this and that participants and researcher are registered professionals, ethical issues for the research study for both participants and researcher were identified. These were discussed in supervision with significant issues recognised to be informed consent, the adult protection experience of practitioners, recognition of abuse that may not have previously acknowledged, responsible use of practitioner time and anonymity/ confidentiality of participants. In the event that abuse was disclosed that had not previously been recognised, arrangements were in place to ensure that the participant was prompted to raise it through appropriate channels; only if a participant refused would it be necessary for me to directly disclose the abuse – acknowledging my responsibilities as a registered social worker. In considering the risks and benefits of participation, the main identified risk was of damage to reputation by disclosure of practice if abuse was recognised. No direct benefits were identified for participants and there were no incentives to participate, a number of participants acknowledged that the opportunity to take time to think about how they make adult protection decisions was helpful. This was not an intended consequence and the interviews were in no way intended to be supervisory or therapeutic.

My project recognises the responsibilities of ethical research and the requirements of being a researcher and a registered, practising social worker. These two identities were especially relevant when undertaking interviews. A discussion of application of ethical principles to my research practice is relevant.

3.8.1 Ethical approval/agreement

Formal University of Glamorgan (now University of South Wales) ethical approval was received from the Faculty Ethics Committee in May 2012 (see Appendix 3). The Faculty Ethics Committee agreement recognised that relevant ethical considerations had been included into the design of the research project.

This study involves no service users/patients and therefore National Research Ethics Service (NRES) ethical approval was not required. This was confirmed with NRES. The project was, however, risk reviewed by relevant NHS Research and Development Committees. Confirmation that the research study was low risk to the NHS was received in May 2012, and a research passport/honorary contract (Appendix 4) was issued covering the period 20th June 2012 – 1st September 2013. The geographical area of the study was subsequently extended as recruitment had been slower than the ambitious timetable identified in the original risk review application, and a new risk review and extension to the research passport/honorary contract was therefore secured (Appendix 4). The research passport and risk review evaluation were recognised in the extended geographical area and this was confirmed at meetings with health managers and in the participant information sheet (Appendix 2).

The ethical consideration process for the involvement of social workers was confirmed with the Association of Directors of Social Services Cymru (ADSS) Cymru as a recommended but not essential step. The ADSS Cymru review did, however, acknowledge the project for all of Wales and provided an introduction to the Directors of Social Services in the identified Local Authority areas, of which I was then invited by ADSS to follow up (email in Appendix 6). This prompted conversations confirming the intention that individual social workers (just as nurses in this study) would need to understand and consent to participation in the study.

3.8.2 Consent and informed participation

Registered practitioners who participated in this study were largely aware of principles of research, informed consent, the obligations of anonymity and the need to disclose abuse. These were not, and could not, have been taken for granted and were outlined in each meeting and interview in order that participants could make an informed decision whether to take part. The participant information sheet which was provided to participants prior to interview (Appendix 2) also clarified the potential risks and lack of direct personal benefits of participation to enable an informed decision whether to participate to be made (Seymour and Skilbeck, 2002). Before commencing the interview, participants were given a verbal summary of the participant information and consent form and had the opportunity to ask questions. Only then were participants asked to read and sign the consent form for their information to be involved. Ahern (2012) discusses that qualitative research can be of benefit to participants but that a researcher must also be clear about potential risks or concerns. The main identified risk was possibility of disclosure of abuse and potential for reputational damage.

The process for this was that the incident/ disclosure would be discussed with the practitioner, exploring the action that had already been taken. In the event that a new adult protection concern was raised in research interviews which required disclosure by the researcher, the procedure and expectations for this were outlined in the participant information sheet (Appendix 2). The participant information sheet was provided to assist members of CLDT to assess the risks of participation and to make an informed choice about doing so. At the start of each interview the consent conditions including disclosure were reiterated and discussed with each participant and agreed by the participant signing the consent form (Appendix 5).

Both in the participant information sheet and in the interview it was confirmed that participation was optional and that consent could be withdrawn. The constant comparison requirements of the grounded theory method were highlighted to the participants who were asked to confirm at the end of the interview if they remained in agreement to taking part in the study. The participant information sheet (Appendix 2) clarified this, explaining that after the end of the interview it would not then be possible to identify and remove their contribution. One participant discussed part way through the interview a phenomenon that Ahern (2012) recognised; a view that research is used to misrepresent participants and to assign a guilt by association to a whole profession in the event that out of the ordinary viewpoints were identified. The participant was given the opportunity to withdraw but when assured that details were anonymised was happy to continue. This caused me to reflect as to whether the comments of the concerned participant reflected the views of people who had chosen not to participate and contributed to difficulties in initial recruitment.

3.8.3 Ethical handling of data

Throughout the research project, a commitment to respecting confidentiality of participating organisations and individual participants was maintained. All information concerning organisations has been anonymised and no identifying features are present. No contact details were passed to me without the agreement of the participant, ensuring that participants were not encouraged to participate by colleagues. Individual participant information was anonymised with participant identifiers used instead of names. All references to service users and geographical identifiers were removed from interview transcripts and stored/transferred to transcribers with password protection in a designated sharing file with access only to myself and transcribers. When participant information was stored as sound files or written documentation it was secured by password protection and data encryption software.

Maintaining ethical standards is just one way to ensure the quality of the research undertaken.

3.9. Achieving academic rigour in qualitative research

Qualitative research has been the subject of much comment and criticism; in particular, this has been directed at the rigour of qualitative research. Credibility, Allen (2010) explains is concerned with truthfulness and honest representation in the research of reality – or participants' perception of reality.

The evaluation measures associated with the natural sciences such as validity, reliability and generalisability were initially believed to be applicable to qualitative research methods and able to establish the quality of the work undertaken (Elliott and Lazenbatt, 2004). Not only has this approach been recognised to be limiting (Slevin and Sines, 2000; Shaw and Gould 2001), but it also does not acknowledge the development, range and differences of qualitative research. The development of different evaluation criteria by authors indicates that one single evaluation does not capture the complexity of qualitative research. Shaw and Gould, (2001) reflect that the application of positivist evaluation methods to qualitative research has been to the detriment of social work research with the potential to restrict or force emerging data. Kirkman (2008) is concerned that whilst the value of credibility and truthfulness in qualitative research cannot be overstated, in a previously unresearched field where further research may be undertaken, these characteristics acquire additional significance. Slevin and Sines (2000) are concerned that good quality qualitative research should represent reality and value credibility and truth as key evaluative criteria, whilst recommending consistency and transferability. Credibility and truthfulness are endorsed by Field and Morse (1985) as essential to qualitative research. This is, however, a challenging position given that in qualitative research there may be multiple realities that emerge and require acknowledgement.

The rejection of positivist research evaluation criteria demonstrates the complexity and post modernity of qualitative research approaches. The need to develop and update the methods by which the quality of qualitative research is evaluated is evidence that the whilst not unified, the methods are dynamic, responsive and rigorous.

3.9.1 Achieving academic rigour in grounded theory research

Within grounded theory debate exists regarding appropriate evaluation criteria. These are broadly attached to the different models of grounded theory and reflect the time, history and development of the grounded theory approach.

Glaser and Strauss (1967) demonstrate this by advocating that the credibility of the original grounded theory method was a direct mirror of positivist quantitative methods in the natural sciences. Allen (2010) who presents a summary of the evaluation methods of four grounded theory methods – Glaser and Strauss (1967), Strauss and Corbin (1990), Charmaz (2006) and Clarke (2005) – acknowledge most favourably the Glaser and Strauss accounting scheme. The Glaser and Strauss (1967) approach values fit, work, relevance and modifiability but has little connection to the role of participant and researcher. Strauss and Corbin (1990) advocate that there are two processes that require consideration, firstly the research process (how the data was derived) and secondly the research findings. The authors suggest seven criteria ranging from sample selection to handling discrepancies and invite readers to ask these questions of the grounded theory researcher. An overview of the evaluation methods is provided in table 3.8.

	Glaser and Strauss (1967)	Strauss and Corbin (1990)
Focus/ priorities	• Fit, work, relevance, modifiability. • Fully integrates emerging theory • Accounting scheme of eight questions to judge quality.	• Research process and research product • Seven criteria for research process and seven criteria for research product. • Theory should be understandable and general (Cooney, 2011)
Criticism	• Assumption that the natural science approaches are relevant e.g. that something is observable (Blumer, 1969) No • recognition of relationship between participant and researcher (Hall and Callery, 2001).	• No structure/criterion for assessing originality. • No recognition of relationship between participant and researcher (Hall and Callery, 2001). • The evaluation criteria may become a circular issue with little scientific generalizability (Elliott and Lazenbatt, 2004).

Table 3.8.Summary of evaluation criteria characteristics in traditional grounded theory.

The criticism raised by Elliott and Lazenbatt (2004) requires recognition that scientific generalisability, occupies an uncomfortable, if not discredited, position in modern qualitative research. Chivrotti and Piran (2003) identify that the key standards by which the rigour of a grounded theory study can be defined are credibility, auditability and fittingness. Slevin and Sines (2000) identify that a grounded theory study should be strengthened by recognising:

- Use of a constant comparative method.
- Internal consistency.
- Convergent truthfulness.

- Respondents and expert involvement.
- Auditability.
- Transferability.
- Providing thick, rich data.

In considering the criteria used to judge the merit of a study, Cooney (2011) insists that the evaluation criteria should be explicit as to how credibility is achieved highlighting that above all grounded theory studies should be clear and understandable.

3.9.2 Achieving credibility in constructivist grounded theory

Constructivist grounded theory is a modern, flexible and responsive grounded theory method. The use of the term flexibility does not indicate that the approach is less rigorous or less disciplined, simply that the participant and researcher are engaged in the research project and product together.

Charmaz (2006, 2010) presents a comprehensive approach to evaluating grounded research. Her focus is upon credibility, originality, resonance and usefulness identified through a series of questions (Charmaz, 2010). The questions identified by Charmaz, (2010, p182) for originality are:

- Are your categories fresh? Do they offer new insights?
- Does your analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your grounded theory challenge, extend, or refine current ideas, concepts and practices?

In particular, Charmaz recognises originality and credibility as being a strong combination of the four criteria that will strengthen the resonance and usefulness of a good research project.

In this Situational Analysis project, a particular challenge exists that Clarke (2005) does not offer significant guidance about evaluation criteria (Allen,

2010). The flexibility of mapping and intense *'wallowing in the data'* (Clarke, 2005, p86) is recognised by Allen (2010) as a systematic and adaptable research design that acknowledges the complexity of post-modern life. This has led to the development of evaluation criteria by each Situational Analysis researcher to map and challenge their own project, demonstrating credibility through this process. Mills, Bonner and Francis (2008) who used elements of situational analysis in their study are concerned with the *goodness* of qualitative research. To do so they borrowed evaluation criteria from Charmaz (2010) and from traditional grounded theory; in particular, that research should be modifiable. A summary of characteristics that contribute towards credible constructivist grounded theory are outlined in table 3.9.

	Charmaz (2010)	Clarke (2005)
Focus/ priorities	• Credibility, originality, resonance and usefulness. Originality and credibility being the most valued of these. • A series of questions that clustered around these four priorities.	• Reflexivity demonstrating routes taken and not taken. • Maps demonstrate systematic research design (Allen, 2010) and activity.
Criticism	No in-depth explanation as to the four priorities is identified (Allen, 2010).	No explicit evaluation framework.

Table 3.9. A summary of characteristics of constructivist grounded theory

3.9.3 Credibility in this research study

This study recognises the mapping method in situational analysis as a powerful tool for understanding data. Establishing and explaining the research process can assist the reader to explore the credibility of the research. This study acknowledges the research process and research product as a focus – derived from Charmaz's constructivist method (2010). The secondary focus of this approach is credibility, originality and usefulness incorporating where Slevin and Sines (2000) contribute to these.

These elements and the methods of achieving them are outlined in table 3.10.

Evaluation criteria (Charmaz 2010)	**Characteristics** Slevin and Sines (2000)	**Method**
Research process Credibility	Use of a constant comparative method. Internal consistency. Auditability Transferability. Providing thick rich data.	Auditability Internal checking.
Research product • Usefulness • Originality	Transferability.	Auditability

Table 3.10 Examples of evaluation criteria in grounded theory.

Credibility, originality and usefulness are key characteristics of this research project looking at the under researched area of adult protection

decision- making with credibility. This is the key criterion in this study for determining rigour. Strategies used in my study to ensure rigour included:

- Discussion in supervision of the experience of early interviews.
- Field notes and memos to cross reference ideas and developments.
- Coding comparisons of two interviews between researcher and supervisor with similarities and differences discussed.
- Use of Nvivo software audit function to provide an auditable record of changes made and merges of codes made.
- Supervision workshop to review the emerging core categories and connected codes, themes and maps.
- Situational, social worlds and positional mapping to test out and challenge emerging themes, routes taken and not taken.
- Project map to present the 'big news' headlines.
- Checking of findings by external supervisor to audit and review the evidence of the emerging findings, themes and core categories.
- A worked example of the use of coding in this research (Appendix 8)
- Reflection upon all stages of the research.

Researcher reflexivity is a further measure used in this study to promote rigour. This is now discussed in the next section.

3.9.4 Researcher reflexivity

The place of reflexivity is not a new debate in grounded theory: Glaser (1992) advocated that researchers should be at a distance from the situation being studied. Conversely, Strauss (1987) acknowledged or expected that researchers would have an existing interest in the research area. Clarke (2005) proposes that researcher reflexivity adds to the rigour of the Situational Analysis method. In so doing, the discomfort that Shaw and Lunt (2012) suggest can exist between the credibility of established traditional research and practitioner–research is challenged and reduced.

Clarke (2005) outlines that reflection is a key factor in post–modern, qualitative research, as the researcher is necessarily involved and immersed in their project and aware and alert to existing knowledge. Critical reflection, for Clarke (2005) is the way in which awareness and understanding of the themes emerging from participant data can be acknowledged and challenged by the researcher. Critical reflection can be an opportunity to value the contributions of participants but it can contribute to recognising and managing sensitive information. Reflexivity challenges the researcher to be increasingly, if not intensively aware of their own experience and opinions. Influences can include personal thought systems, existing theoretical ideas and knowledge of the subject (Etherington, 2004), especially as a practitioner–researcher. Reflexivity, in this research is the skill of remaining open and impartial to the process whilst acknowledging how the emerging data may be applicable to practice issues. A reflective diary was kept throughout the process in addition to research field notes. Reflexivity has been achieved in this study through discussion in supervision, use of reflective diary/journaling, theoretical memoing and continually tracking processes, developments and changes using Situational Analysis (Clarke, 2005) mapping techniques. When researching a topic such as adult abuse and working with participants to explore their work in this area, reflexivity has additional relevance. Supervision discussions and use of memos (see Appendix 9) have assisted this process.

3.10 Summary

This chapter has discussed methodological options and identified a qualitative methodology as appropriate for this PhD study. Recognition of the evolution of grounded theory from Glaser and Strauss (1967) to Charmaz (2010) identified that Situational Analysis (Clarke, 2005) was an appropriate choice for this study. Situational Analysis, a developed form of grounded theory, is appropriate for this research as it promotes deep exploration of influences upon participants' adult protection

decisionmaking. The data gathering method of semi-structured interviews which were adjusted over the course of the project ensured that data gathering remained relevant and disciplined whilst gaining and responding to rich and detailed emerging data. The detailed and intense use of interview data to code, memo and develop an essential series of maps to facilitate analysis at the micro, meso and macro levels that Clarke (2005) identifies as necessary. The themes derived from participant interviews using the chosen methodology, method and data analysis techniques are discussed in the next two chapters. Chapter four introduces the early emerging themes and uses relational mapping to support these discussions.

Chapter 4. Findings: emerging themes and relational mapping

The first of two findings chapters, this chapter acknowledges the categories that have been identified from the initial analysis of interviews and management of initial codes. The data analysis approach outlined in the previous chapter was used to develop codes and later categories, these then contributed to the recognition of emerging themes, developed through a series of relational maps (a form of situational map). Table 4.1 summarises the four theoretical categories and core category (discussed in chapter 6) that emerged from the participant data further to analysis and mapping. Presented as five discrete and individual categories they are each intertwined and impact upon each other. The discussion of each category includes, and is prefaced by, a relational map drawing out and acknowledging the key relations, relationships and conflicts in the emerging data. As part of theoretical sampling, relevant literature is also considered with the emerging findings, ensuring that the characteristics of grounded theory are incorporated and valued.

Categories	Core category
• The official line • Expectation and perception • Non vulnerable adult process options • Confidence and competence	**The tipping point**

Table 4.1 Categories and core category

4.1 Social world mapping

Introduced in chapter 3, social worlds maps are a means of exploring the meso or middle level of analysis. The strength of the social world map is not detail but the recognition of sites of power and influence, whether recognised by participants or not. Figure 4.1 presents the social worlds

map for this project and acknowledges the presence of a number of situations of interest. To give an example, what can be seen from this social world map is; the overlapping of conditions and interrelations between micro-elements such the family of the adult with a learning disability and the meso conditions such as a Local Authority or specialist safeguarding roles. The porous boundary between each actor and the centre – adult protection decision making – denotes that these characteristics are constantly changing and interrelating with each other at different times.

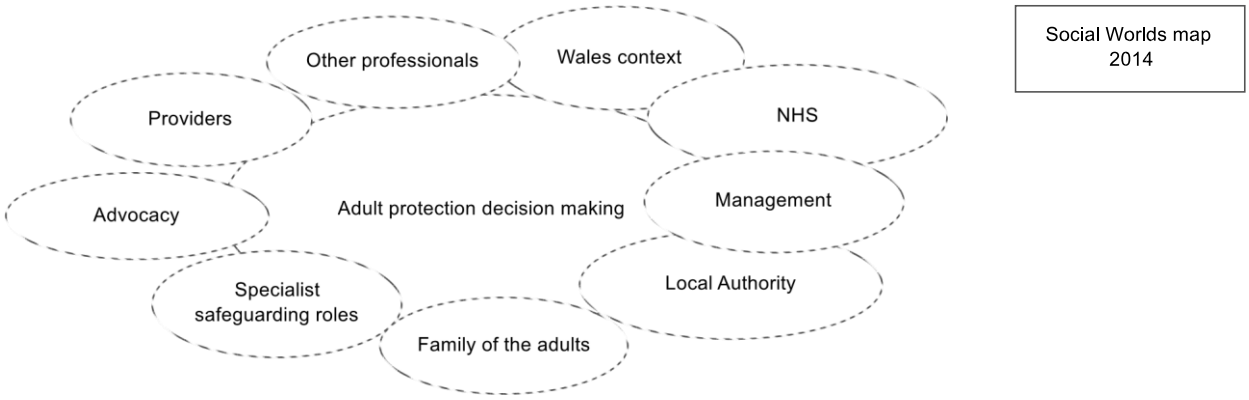


Figure 4.1. Social worlds map - Adult protection decision making in a CLDT.

Whilst the boundaries and relationships between the actors in this social world map may change prominence over time, they remain present and shape the meso context in which nurses and social workers make decisions about abuse. The social worlds map for this project is presented here as it sets the scene against which the emerging themes occur and further more detailed relational mapping in this chapter has taken place.

4.2 Emerging findings: official line

This category, entitled the *official line,* relates to how nurse and social work participants, understand, interpret and make sense of available and proposed adult protection legislation, policy, research and guidance. *The official line* is how and what participants understand as the rules of adult protection practice – the formal structure (however derived) that nurses and

social workers recognise as a statutory framework for their practice. This category presents evidence that not only formal or published sources contribute to participant's identification of the official line but that the interpretation of these sources and application to practice on a local or regional basis was also significant. The characteristics of this *official line* are now discussed, starting with a relational map in figure 4.1 that demonstrates the relationships identified in this category.

4.2.1 The official line: relational map

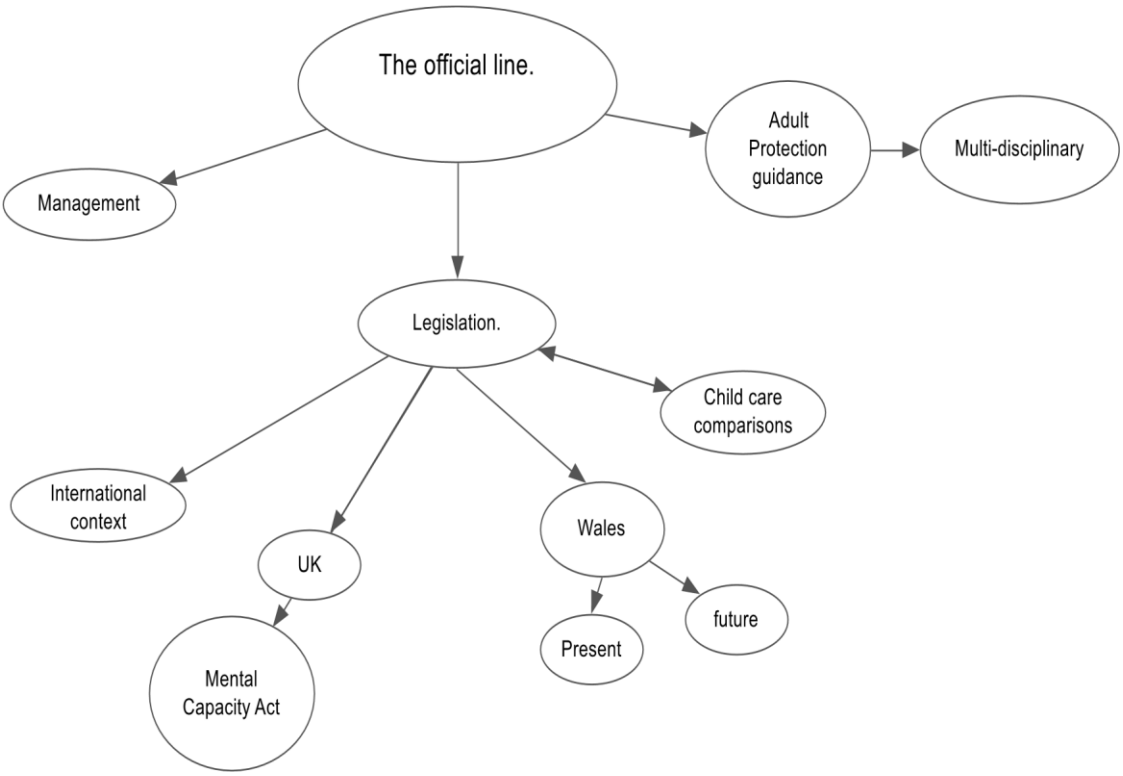


Figure 4.2 Relational map - The Official Line.

The relational map (figure 4.2) is the product of refining and re-working the data attributed to the category *the official line* through a series of initial, axial and selective codes. These key influences include present legislation (and lack of adult protection legislation), statutory guidance and how management are expected to be the custodians of the application of these to adult protection practice. The influence of devolution upon practice in

Wales and the future of health and social care legislation for Wales also acknowledged in this category.

Appendix 8 presents an example of how initial codes were identified in one participant interview – an approach that was used for all initial codes. Table 4.2 is an example of how working with codes arising from participant data contributed to the identification of the key influences in *the official line* category. Following the table, each of the selective codes is then explored.

Initial codes	**Selective codes**	**Category**
Wales, UK, International, future, present, past.	Legislation	**The official line**
Choice, court of protection, best interests, consent, choice, who chooses?	Mental Capacity	
Care management, adult protection, risk, resources and eligibility.	Assessment	
Specialist roles, DLM, investigator, threshold for action, advice, guidance, process, poor practice, provider issues, screening, social services, sanction.	Adult protection process	
Support, availability, experience, clarity, decision.	Management	
Social services as lead, NHS, Police, local process, local agreement.	Multidisciplinary	

Table 4.2. Coding themes contributing to the identification of key relations in the official line category.

4.2.2 Legislation, guidance and adult protection

The literature review recognised that adult protection requirements, policy recommendations and practice guidance are not explicit in legislation in Wales. Instead, legislation from across a number of sources and supported or developed by guidance - largely *In Safe Hands* (NAW, 2000) - is used and referred to as part of a formal framework for adult protection work. Participants largely acknowledged and understood that *In Safe Hands* (NAW, 2000) was not legislation and that legislation that was applicable to adult protection action was borrowed from other sources in order to protect adults. Whether this was considered to be a positive or negative to decision making practice was discussed by participants. Social Worker 14 lamented the lack of legislation available to practitioners working with adults whilst acknowledging that they have to make the most of the existing opportunities to safeguard adults:

> *…'We haven't got the legislation to follow things up via the courts. The most frustrating thing is, is that we don't have that legislation…Yea, I don't know, I suppose because we haven't had it, you work with what you've got.'… (Social Worker, 14)*

Prompted to discuss adult protection legislation two perspectives require recognition. The first is the view in which a nurse suggested that *In Safe Hands* (NAW, 2000) was referred to or understood *as* legislation, the second is a review of the current status of no legislation, and the identified advantages and disadvantages of this. It is significant that at the time of data collection for this study 2012 -2013, preparations and draft proposals for the introduction of the Social Services and Wellbeing (Wales) Act 2014 (Wales,2014) including proposals to include adult protection into legislation had recently become available for consultation. Whilst the details of the final safeguarding regulations to the Act were not available during the lifetime of this study the commitment to five key principles were known and anticipated to permeate adult safeguarding guidance. These principles are expected to inform developments in practice with adults at risk of abuse. The key principles (Care Council for Wales,

2015a) are increased voice and control (including advocacy), prevention and early intervention, the promotion of well-being, coproduction (working with individuals towards agreed outcomes) and multi- agency cooperation.

Each of these key principles has (or is expected to have) a direct impact upon the individual practice of each practitioner to ensure that the potential or actual impact of abuse is explored, shared, reported and where possible reduced. Whilst the Social Services and Wellbeing (Wales) Act 2014 (Wales,2014) may be (inaccurately) perceived as applying only to Local Authority staff the key principles apply to both social services and NHS colleagues. The success of these principles becoming embedded in adult protection practice across health and social care is likely to depend upon more than the introduction of legislation.

That *In Safe Hands* (NAW, 2000) is not legislation may generate surprise to the general public and new practitioners. Nurse 2 identifies that the process guidance contained within it and the *All–Wales Interim Adult Protection Policies and Procedures* (SSIA,2010) has been incorporated into practice as if legislation. Nurse 2 commented:

> *'…you feel like all the boxes have been ticked and everything's um checked if you like, signed off and appropriately acted upon. You've got the legal framework assisting you'… (Nurse 2)*

The rationale for advocating a legal framework in this instance is also described by Nurse 2 as offering protection or accountability to staff rather than (or as well as) to adults. Nurse 2's description of process being applied to practice *as if* it is legislation may risk reducing the main principles of *In Safe Hands (NAW, 2000)* simply to a process to be followed. If guidance is accepted *as if* legislation, then the significant changes in referral patterns identified by CSSIW (2010) that coincided with the introduction of *All–Wales Interim Adult Protection Policy and Procedures* (SSIA, 2010) have additional resonance. It may indicate that Local Authorities, their

safeguarding partners, and individuals such as Nurse 2 have not only adopted the 2010 guidance as helpful but 'as if' legislation.

The second perspective raised by participants identified legislation as having the potential to add clarity, and potentially resources, to the current situation and to enhance the status of vulnerable adults and adult protection practice. This view was most strongly articulated by social workers with Social Worker 19 indicating that legislation could support, clarify or provide opportunities to intervene in situations of potential abuse, easing decision - making dilemmas for the social workers. Social Worker 22 identifies that legislation may not only clarify and aid the social work role but also ensure that adult abuse concerns are valued and prioritised. This is not to suggest that legislation alone would change the way that abuse is identified, reported, and responded to in Wales or that the need for nurses and social workers to make decisions would disappear. What the introduction of legislation has the potential to clarify is that adult abuse is recognised as unacceptable, so unacceptable that the law provides an opportunity to intervene and apply penalties.

> *… ' I think, I think it's really important I think it should be enshrined in law absolutely, definitely. If you've got the backing of the law it's, it makes your job so much easier and more clearcut, absolutely'…(Social worker, 19)*
>
> *…'I do think it needs more, I do think it needs stronger legislation to enable this to happen, because I think otherwise the protection of vulnerable adults sort of, doesn't get swept under the carpet, but can get sidelined, so there's no way to progress'… (Social worker, 22)*

The comments of Social Worker 19 indicate that legislation was perceived as adding clarity if not certainty and consistency to adult protection decisionmaking. This view mirrors Collins (2010) appraisal that the practice guidance on referral thresholds contained within the *All-Wales Adult Protection Policy and Procedure Interim Guidance* (SSIA, 2010) adds clarity to practice decisions and that these remain under review for

inclusion into the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014).

Participants made comparisons to child protection legislation identifying this as more robust, recognised, and respected than the opportunities open to adults and practitioners working with adults. Two considerations arose from this comparison with childcare; the first is again the view that the status of law signals an intent that abuse of adults is a serious matter, the second part of the comparison is the link between adults with a learning disability and children having similar vulnerability.

> *… 'It would be maybe more robust and why any different from children really, we're still dealing with vulnerable groups'… (Nurse, 2*)

> *…'I've, I've read the Bill, it's more like the Children's Services, isn't it? I've read the bill and I think it's a really good idea. I don't see what the difference is, whether you're protecting an adult or protecting a child, you know, especially if that person has, lacks capacity, you know'… (Social Worker 12)*

Direct comparisons between adults and children are not unproblematic with an existing pervasive perception that adults with a learning disability are eternal children (Wolverson, 2011 p326). Social Worker 11 acknowledges this and raises that comparisons with childcare or the direct application of childcare legislation practice to adult protection may be inappropriate:

> *… 'I suppose adults, they are so different from child to adult, they have different needs but um I think it* (the introduction of legislation) *would be clearer and possibly we'd have more of a duty actually'...(Social Worker 11)*

All participants, whether the first or last interviewed were prompted to share views, understanding and experience of legislation and adult protection. Not all social workers had strong opinions about the current non-legislative status of adult protection work, but each had something to contribute or comment upon; most usually reflecting upon their own experience to do so.

Northway et al. (2007) identified that participants in their study (drawn from a range of learning disability agencies and providers in Wales) that included health and social services representatives, considered adult protection to be the responsibility of Social Services. If this remains a characteristic of contemporary learning disability practice, it is less surprising that social workers have a greater awareness of the detail of adult protection legislative status and challenges associated to decision making than nurse colleagues.

Domestic legislation in Wales exists and operates within a broader legal context that incorporates UK, European and International perspectives. The Human Rights Act 1998 derived from the European Convention on Human Rights was not explicitly acknowledged by participants although characteristics of the Act were referred to. The suggestion that there could be a duty to intervene even where adults appear to be able to make informed decisions about their own risk would amend the existing legislative basis for adult protection practice. Social worker 14 acknowledged the Mental Capacity Act 2005 (Great Britain, 2005), which is explored next, as a key feature in adult protection practice, especially in the absence of adult protection legislation: *'you've got the lack of legislation as well but the big issue is capacity'... (Social Worker 14).*

4.2.3 Mental Capacity Act 2005 and Best Interests

Developed and enacted prior to the devolution of law making powers for health and social care to the Wales, the Mental Capacity Act 2005 therefore applies to England and Wales (but not Scotland or Northern Ireland) with one code of practice that covers both nations. The starting point of the Mental Capacity Act 2005 is that an adult should be presumed to have mental capacity and therefore able to make informed decisions about their life unless there is indication to the contrary. Adults who can (and are assessed as having capacity by a relevant professional including social workers and nurses) make decisions about their own risks retain the

opportunity to do so; however unwise the decision may be considered to be. This key principle of respecting informed but unwise decisions underpins the Mental Capacity Act 2005 that may include a decision being made not to pursue adult protection report when an allegation of abuse has been raised. The relationship between adult protection and the Mental Capacity Act 2005 requires further discussion as it is one of few pieces of legislation that applies directly to adult protection issues.

Where an adult lacks mental capacity to make an informed decision on a specific issue, the Mental Capacity Act 2005 requires that a decision should be made in the persons 'Best Interests' which may include a decision to safeguard an adult. Acting in an adult's 'Best Interests' may require that action is taken (and possibly authorised by the Court of Protection) that may be contrary to the stated wishes of the adult without mental capacity or their friends and family. The responsibility surrounding these decisions and the expectation to *correctly* establish mental capacity, featured strongly in participant interviews. Participants reflected upon achieving an appropriate balance between understanding and assessing unwise decisions and the necessity to intervene in the adult's Best Interests:

> *… 'I'm not overstepping the mark in relation to what's right for them because they can make unwise decisions as well, so, you know we've got to be very mindful that we get the balance right'... (Social Worker 21)*

> *… 'You know, and then you have other clients who are sort of borderline and yes they can say actually I don't want to live there or I don't want to do that I don't like it, but they won't understand the consequences of that decision'...(Social Worker 11).*

Each Mental Capacity Act 2005 decision is considered unique and specific. A person may be able to make some decisions about their life but not be able to make others. McDonald (2010) explains that whilst adults with the ability to make unwise decisions may do so, a practitioner involved in a proxy decision for an adult without mental capacity must make a good (if

not wise) decision. The quality of each assessment and subsequent decision (referred to as a Best Interest decision in the Mental Capacity Act, 2005, (Great Britain, 2005) is therefore directly connected to making decisions that secure good outcomes for adults with a learning disability; including good safeguarding outcomes. Wilner et al. (2011) identified that amongst the NHS staff involved in their South Wales research project the responsibilities and principles of the Mental Capacity Act 2005 (HMSO, 2005) were frequently misunderstood. Despite further training aimed at explaining the application (and importance) of the Act, Wilner et al. (2011) reported that understanding amongst NHS staff of the Mental Capacity Act (HMSO, 2005) remained, at best, inconsistent. This raises several queries as to how mental capacity assessments are prompted, understood and undertaken and when they are considered to be necessary by staff.

When assessments indicate that an adult with a learning disability does not have mental capacity to make a decision about their own situation (including abuse), a Best Interest decision is required. In some circumstances, a judgement from the Court of Protection to endorse or deny the proposed Best Interest decision may be required. Consequently, this may not provide (or be perceived to provide) a quick solution to immediate safeguarding concerns where an adult is at risk. Nurse 13 described the distress that she experienced when a Court of Protection decision was required to enforce the Best Interest decision that had arisen from a safeguarding concern. The distress or discomfort identified was derived from the responsibility to make decisions in place of the adult especially where this decision is in conflict with the individual or their family.

> *…'I think this is why this was very emotional for me working with that case that I could see how distraught the mother was, it was awful, and worked with her for 20 odd years and tried to prepare her for this inevitable crisis and when she was going to be no longer able to care for her daughter but she wouldn't plan at all…' (Nurse 13)*

The impact of dissonance between the views of the practitioner and the views of family is explored later in this study as they are identified as being particularly significant. Increased use of this process is likely to increase practitioner exposure to the Court of Protection with corresponding greater scrutiny of nurse and social work decisions. Whilst practitioners expressed broad satisfaction with the idea of further and future development of adult protection legislation, caution and interest were also raised, as to how existing law and practice would be reconciled.

4.2.4 Future legislation in Wales: Adult Protection and Support Orders

The Social Services and Wellbeing (Wales) Act 2014 (Wales,2014), proposes a single definition of abuse and neglect for both adults and children. Clements (2014) anticipates that when the final code of practice for the Act is published, it will contain much of the content and principles of the *In Safe Hands* guidance (NAW, 2000) with additional reference to the new powers to be introduced. As well as formalising adult protection in legislation a significant development of the new provision is the proposal of Adult Protection and Support Orders. These are likely to provide for an authorised representative of a Local Authority to gain permission from a magistrate to allow a conversation, in private with an adult to assess whether the adult may be at risk. This is not the same proposal as has entered into Scottish law where a power to assess and to remove the person is provided by the Adult Support and Protection (Scotland) Act (2007). Mackay (2008) writing at the introduction of the Act to practice in Scotland identified that the challenge of broader adult safeguarding strategy would be to integrate this with existing legislation including the Scottish equivalent to the

Mental Capacity Act. The practicalities of the Act at the time of Mackay's (2008) writing were largely untested. How practice in Scotland had adapted, as a result of the introduction of the Adult Support and Protection (Scotland) Act (2007), has not yet been evaluated.

Although the powers of the Adult Protection and Support Orders are likely to be available (only) to the Local Authority, all participants were asked about the potential of this proposal. The responsibility to initiate a request for use of the order is, however anticipated to rest with nurses (and other professionals) as it will social workers. Practitioners commented:

> *… 'it's certainly a very good idea, because at the moment, um, we've had one scenario where professionals were being denied any access to a vulnerable adult, and it had to go down the court of protection route'… (Social Worker 7)*

> *… 'Well I think every bit of help and power you can get, well power's not the right word but something you can hang the work on, I suppose, is a help, because, as you, as you said it's frustrating, plus there isn't a great deal on occasion that you can do, unless the situation's so bad, and somebody's had a very bad time to get to that'… (Social Worker 15)*

The comments of these social work participants mirror those made in relation to the Mental Capacity Act 2005 – that additional statutory measures are considered helpful, even desirable, although exercising them can be cumbersome, resource intensive and take time. Social Worker 7 notes this comparison between the proposed orders and the current access to the Court of Protection for decisions in relation to adults who are not able to make an informed decision for themselves. The comments of social work participants indicate that an Adult Protection and Support Order, used as a last resort may in some circumstances be necessary. Nurse 24 expressed caution regarding this development suggesting that it may affect trust and relationship between service users and professionals:

> *… 'So, developing a rapport is very important... With a warrant (or order) at her door, you'd have a brick at your head I think'… (Nurse 24)*

This reservation is interesting given that whilst the nurse may initiate the use of an Adult Protection and Support Order it is unlikely that they themselves will be the professional at the person's door. In contrast, Social

Worker 10 who was familiar with a similar power under the Mental Health Act 1983 (2007) identified the dilemmas associated with the use of compulsory powers in the community:

> *… 'I think they're going to have to be very, very careful. I think it's a massive; it could be a massive power (laughing) that's abused hugely. I don't know why I'm giggling because I think it's terrible I genuinely do but I can see just in one or two ... cases here, you think oh my God that person needs to, you know, something needs to be done and there's absolutely nothing we can do about it, nothing at all. At least with the Mental Health*
> *Act it's very, um, you know there's rules, there's boundaries, there's, it's there, its law'… (Social Worker 10).*

The regulations or code of practice to the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014), may (or may not), once published relieve some of the concerns that Social Worker 10 has, by providing practice guidance. This comment raises that the *Mental Health Act 1983* (2007) has an established place in law, it is accompanied by a code of practice for Wales and is constantly tested through case law, which in turn directs and contributes to the development of practice. New legislation is by definition without this refinement and test, therefore the certainty of the application of law to practice that Social Worker 10 describes may not immediately be available with the Adult Support and Protection Order.

Where a practitioner is authorised to access the private home of an adult believed to be at risk it must be in accordance with the requirements of other domestic and international legislation, for example the Human Rights Act 1998. A Local Authority representative exercising the powers of an Adult

Protection and Support Order under the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014), must also determine if an adult is making decisions freely. This recognises that the requirements of the Mental Capacity Act 2005 would continue to be relevant.

Faced with such decision making, Social worker 20 draws a parallel with the dilemmas expressed in relation to mental capacity, recognising that decision making ability and the right to take risks can be used to obscure or not recognise vulnerability. Whilst expressing that their own practice may be overcautious they acknowledged the difficulty in accepting decision making ability as shorthand for moving complete risk taking responsibility to the adult without any further support.

> *…'If somebody comes along and says well you're impinging on that person's rights and choices, I would prefer to be criticised for being over-cautious rather than a little bit blasé, hiding behind the thing that [it's] people's rights and people's choices.'… (Social Worker 20)*

Just one participant (a social worker) identified or commented upon the existing power under the National Assistance Act 1948 s47 to remove an adult from their situation (regardless of their ability to make a decision). Like the proposed Adult Protection and Support Order, the use of the existing power is limited to the Local Authority, although it requires the input of the health colleagues. In Wales, the anticipation is that s47 of the National Assistance Act 1948 will be repealed. With no proposed power of removal attached to the Adult Protection and Support Order, Clements (2014) reflects that Wales has taken a unique direction between the English and Scottish approaches. He suggests that the Welsh position has the potential to be the 'worst of both worlds' (Clements, 2014, p16) as the Act proposes no power to act if a person is assessed to be at risk (but with mental capacity on the matter) whilst the repeal of the s47 removal takes away the one power that is currently available.

Whilst interviews with all participants prompted discussion of legislation, nurses had fewer views to offer regarding potential changes or opportunities. If, as discussed above, adult protection practice is viewed as the responsibility of Local Authority social services departments then the profession of the main contributors may not be surprising. Whilst this section has addressed and considered the potential impact and opportunity of the introduction of future legislation, it is the current guidance – *In Safe Hands* (NAW,2000) and the *All– Wales Interim Adult Protection Policy and Procedures* (SSIA, 2010) - that was identified as having the greatest influence upon current practice.

4.2.5 In Safe Hands: National guidance - local interpretation

*In Safe Hands (*NAW, 2000) was published in 2000 to introduce formal adult protection policy and guidance to Wales. It is anticipated that any legislative change will echo the current principles of *In Safe Hands* (NAW, 2000). The 2000 guidance has a central principle that multidisciplinary decisions are good decisions and that professionals should work together to achieve this.

Policy guidance was adjusted little in the first decade of existence whilst practice guidance to *In Safe Hands* (NAW, 2000) developed in regional clusters across Wales. The *All–Wales Interim Adult Protection Policy* (SSIA, 2010) was a practice led initiative to consolidate these regional approaches and to develop consistency. It is recognised as current practice guidance (although it is not directly published by the Welsh Government but by SSIA - an agency of it) whilst *In Safe Hands* remains the current policy. This difference is significant as the existence, understanding and application of policy is the recognised basis for adult protection work. During the interviews participants directly referred to the *In Safe Hands* (2000) policy guidance as their basis for practice:

> *… 'Well, you know, I understand the safeguarding, you know, 'In Safe Hands'… (Nurse 25)*

This is the only quote in which a participant directly referred to *In Safe Hands* (NAW, 2000) and there was just one reference in the whole project to the *All–Wales Interim Adult Protection Policy and Procedures* (SSIA, 2010).

Social Worker 3 referred to it as the *'DLM POVA pack'* and described it as:

> *… 'a really useful guide, a prompt; always … my first port of call'… (Social Worker, 3)*

Social Worker 3 is one of three participants in the study who also undertakes the role of Designated Lead Manager (DLM). Social Worker 3 might, as a consequence, be expected to have a greater awareness of adult protection policy. A key feature of the *All–Wales Interim Adult Protection Policy and Procedures* (SSIA, 2010) is the commentary on establishing a threshold for raising an alert; which Collins (2010) evaluates as helpful to colleagues. The comment of Social Worker 3 that the *All–Wales Interim Adult Protection Policy and Procedures (SSIA, 2010)* is a 'DLM POVA pack' identifies that it is considered as a series of practice guidance, policies and procedures aimed not at practitioners working directly with adults but at managers once the safeguarding alert has been raised. This is relevant because until a decision is made and an alert raised the role of the DLM does not exist, the comment demonstrates that the role of the DLM in the adult protection process was misunderstood**.** The same comment may also reflect the development of local and regional responses including the addition of the role of DLM to Team Manager responsibilities had been understood to be one and the same role. Confusion about the role of the DLM was not however, a unique view to one worker or to one geographical region:

> *… 'the DLM is the main lead investigator'… (Social Worker 12)*

> *… 'I was just gathering info to be passed onto the DLM, for her to make a decision on how to proceed, really… (Social Worker 22)*

4.2.6 Managers as the official line

In exploring the data, and revisiting early codes to understand the relationships between them, it became clear that whilst practitioners frequently sought guidance, it was not from formal policy except from managers and safeguarding staff. To individual nurse and social work practitioners, managers emerged as interpreters of policy and guidance – to practitioners it became clear that managers themselves represented the official line:

> *… 'I think basically it's just querying everything that any niggles in your mind, if there's a query to see your um POVA team or colleagues and record it all really so you can have a, just think 'cos those things can just sit in the back of your mind otherwise wouldn't they, if you don't act on them'… (Social Worker 20) (I raise concerns) … 'either via consultation with social worker or manager'… (Nurse 4)*
>
> *… 'I would normally bring it back, I would generally discuss with a few colleagues or discuss it with my manager, or even if there was a disagreement we would take it to a wider MDT. '… (Nurse 5)*

Of interest here, is whether individual nurses and practitioners feel a personal, professional connection or responsibility to the principles and processes of *In Safe Hands* (2000) and *All–Wales Interim Adult Protection Policy* (SSIA, 2010) or whether this is passed to managers.

The use of individual managers as guardians of the official line requires recognition. Individual managers' understanding will be influenced by local characteristics developed as a response to local circumstances, history and reflecting the resources available. In the same way, the *official line* that individual nurses and social workers may identify or experience is itself informed or filtered by their own managers safeguarding priorities. Consequently, as practitioners within CLDTs, nurses and social workers, as well as their managers (and the relationship between them) contribute to the determination of the threshold for action; the application of guidance to practice is likely to vary throughout Wales.

4.2.7 Summary

This section has noted the influence of the official line – how policy and guidance feature in the awareness and practice of participants in this study. Summarised crudely; the official line is the rules of the game for adult protection practice. The official line is the starting point from which organisations, regions and individuals in Wales have developed or filtered local and individual practice responses. In turn these responses are now recognised and accepted by nurses and social workers not as an interpretation of the 'rules' but as the rules themselves. The official line is not one single set of rules or legislation, instead adult safeguarding borrows and uses legislation (where it is relevant to do so) to secure a positive outcome for the vulnerable adult. Where legislation or guidance is unclear, conflicting, difficult to use or requires time and resources, it is more likely to be subject to local interpretation. This local interpretation filters, develops and defines how policy and guidance are applied to nurse and social worker adult protection decision making. Across South Wales it is possible that there may be as many official lines as there are managers in CLDTs.

Participant's responses demonstrate that details or expectations of policy and guidance are not fixed; neither is their understanding of these. Whilst participants acknowledged existing adult protection policy and procedural guidance they were also aware of dependence upon other legislation such as the Mental Capacity Act 2015 for it to be effective. Acknowledging the complex legal and policy situation did not emerge as being the same as understanding it. Participants identified misunderstandings about what was and what was not legislation. Whether the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) and the introduction of adult safeguarding legislation will clarify individual practitioner expectations, is not yet known.

If legislation and guidance are the *official line* of adult protection decision making practice, then participant expectations and perceptions are how

participants expect and experience the official line when applied to their practice.

4.3 Emerging findings: expectations and perceptions

The first focus of this section acknowledges the link between how staff understand the *official line* and the expectations that they experience upon their own work as a result. The second focus of this category explores participants' perceptions of adult protection policy, process and practice and how this may influence individual practitioners' decision-making. Perception in this section is the experience that participants have of how the expectations, described in the official line are applied in practice. If the official line can be summarised as the rules of the *game*; expectations and perceptions are how those rules are interpreted by nurses and social workers and how they believe that the game should be, and is *played.*

Figure 4.3 is a relational map of how the key elements relate to each other.

4.3.1 Expectations and perceptions: relational map

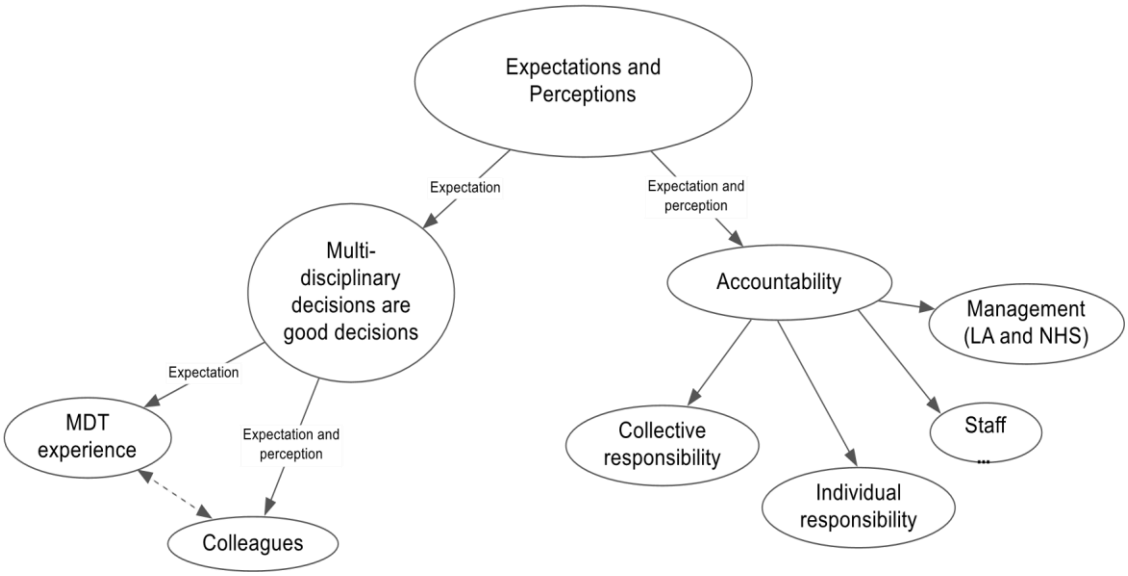


Figure 4.3. Situational/relational map: Expectation and Perception

The relational map is the product of refining and re-working the data through a series of initial, axial and selective codes. Table 4.2 demonstrates how, through the use of coding, the characteristics of this category were identified, refined and the category *expectation and perceptions* confirmed as relevant.

Initial codes	Selective codes	Category
Good decisions, poor decisions, clarity of roles, conflict, agreement, colleagues, relationships, proportionality, honesty, (mis) understanding of the DLM role.	Multidisciplinary decisions	Expectation and perception
Management (LA and NHS), staff protection, individual responsibility, collective responsibility, not my decision, vulnerability, specialist roles, social services as lead, NHS, Police, local process, location of abuse.	Accountability	

Table 4.3 Coding themes contributing to the identification of key relations.

The identification of the selective codes of *multidisciplinary* and *accountability* derived from participant comments. Participants identified that adult protection practice was closely aligned with accountability. Accountability included multidisciplinary accountability as well as individual and management accountability, which all emerged as relevant key themes. Participants identified that they expected to be part of

multidisciplinary work to safeguard adults, and that this was expected of both nurses and social workers by the
In Safe Hands (NAW, 2000) guidance and their employing agency. The perceived effectiveness of multidisciplinary work in securing good safeguarding outcomes for vulnerable adults generated mixed and varied views as to whether multidisciplinary decisions are always good decisions.

4.3.2 Multidisciplinary decisions are good decisions

In Safe Hands (NAW, 2000) refers to multidisciplinary practice as a central expectation of adult protection practice. It has already been acknowledged that policy developments in relation to learning disabilities in Wales since the 1980s have encouraged, if not mandated, multi-professional working (as outlined in chapter 2). The undertone of each recommendation that agencies work together is that multidisciplinary decisions are good decisions, although the literature review provided mixed evidence that this was always the case. Slevin et al. (2007), for example, summarised that much of the existing literature related to the success of multidisciplinary CLDTs is aspirational rather than evidence based.

Smith and Anderson (2008) suggest that the intention of the drive towards multidisciplinary working is to promote consistent and effective adult protection work, especially where health and social care interface. Whilst Local Authorities became the lead organisation for adult protection in the community, under *In Safe Hands* (NAW, 2000) the expectation is that a range of organisations including the NHS and the Local Authority will work in partnership. Partnership implies an even if not equal relationship between the agencies, Participants described their experiences of this relationship. One nurse participant described that as care manager she had been required to undertake a risk assessment to consider whether there were triggers for an adult protection referral to be made, an action that was experienced as a disproportionate burden, considered to be at odds with their role as nurse care manager.

… 'It generally does tend to come to the nurses, I think it should be the person who knows the person best, but the nurses always seem to get it'… (Nurse 5)

In this situation Nurse 5 was the care manager for the adult but felt that a social worker, who was also aware of the adult, was a more appropriate person to undertake the risk assessment. Not all nurses expected that undertaking an adult protection task was part of their role at all. Nurse 2, when asked about their own role in adult protection, clarified their expectation of involvement:

…'it's my understanding that social services usually take the lead on these things so I would report back to social services'… you make the social worker aware and they do call at the home as well'… (Nurse 2).

Nurse 2 identified that as a nurse care manager they did not identify it as part of their responsibility or that they were expected to make a decision on whether or not to raise an adult protection alert. Even before an alert is formally raised, and where there may be no existing social services involvement, Nurse 2 identifies that social services colleagues are expected to assist with welfare visits where abuse may be a possibility. At the very least, where initial concerns may be recognised Nurse 2 anticipates that these are directed to social services rather than their own line management. This experience is supported by Nurse 4 who also commented upon significant differences between social services and health as to when an incident constituted abuse:

… 'I think the difference between health and social service professionals could also impact on when a POVA is raised'… (Nurse 4).

This was clarified by adding that it was their own experience of raising concerns and inviting an opinion from social services as to whether an incident was abuse or not. However, this had, at times, resulted in frustration as incidents raised had been assessed by social services as poor practice rather than abuse and no adult protection process was

initiated. Nurse 4 then clarified that, to their frustration, as the incident had not entered the formal adult protection process (and responsibility passed to social services) they had consequently been expected to case manage the identified risks themselves.

The comment demonstrates an emerging picture in which nurses direct concerns - at an early stage to social services – even if individual nurses themselves are not clear if abuse has occurred. Nurses' comments indicate both an expectation and a perception than the Local Authority is expected to screen risks identified by other professionals, to advise whether an adult protection alert exists, and to direct if/what further action is required. This was a pattern of practice recognised by Social Worker 3:

> (Health) *… 'seem to think a social worker is responsible for all things'… (Social Worker 3)*

Noting that participants were drawn from across South Wales and not just from one locality it appeared to be a widespread expectation that all concerns about adult abuse should be directed to social services. This echoes the findings of Northway et al. (2007) that participants from a range of health and care settings considered adult protection to be the (lead and sole) responsibility of social services. The comments also indicate that personal, and possibly professional tolerance to risk, differs between health and social services colleagues causing social services to become, by default the decision maker as to whether adult protection action is required. The expectation of *In Safe Hands* (NAW, 2000) is that *after* adult protection risks are identified, the Local Authority will *coordinate* a multidisciplinary response. Where alternative practice has developed, regardless of the expectations of *In Safe Hands* (NAW, 2000), it has been given the opportunity to become custom and practice, reinforcing the perception that adult protection decisions are taken by social services. The Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) is anticipated to introduce a duty to report abuse where it is identified. Whether this will be an opportunity that social services take to encourage nurses, and other

healthcare professions, to assess and define the risk and vulnerability that they identify, and raise an alert themselves without the early, often informal input of the Local Authority is unclear. If such an approach is taken, it has the potential to redefine expectations between nurses and social workers and their employing agencies. How the duty to report abuse may affect practice was not explored in this study as this detail was unknown at the time of data collection. Whether the seemingly casual current process/ conversations in which social services staff are asked to assess and screen incidents of potential abuse on behalf of health colleagues will be viewed as a fulfilment of the professional duty to report abuse, is unclear. It may be that a duty to report abuse requires nurses and social workers to explain their assessment of risk at the point of reporting through one central reporting structure.

Once an abuse alert had been raised (formally or informally), a perception that the risk had transferred from the referrer to the adult protection process and in particular to the chair of the process – the Designated Lead Manager (DLM) was not uncommon. Referring to one incident in which immediate safeguarding measures were required in response to concerns raised by a nurse colleague, Social Worker 3 (who also fulfilled the role of DLM) commented:

> *…'I had to go down and tell the family because the nurse had buggered off* (end of the working day)... *and the social worker hadn't attended' (Social Worker 3)*

Developing practice in this way has the potential to negate the multidisciplinary benefits anticipated by *In Safe Hands* (NAW, 2000) as dilemmas referred to social services for guidance and support will also default to be by one agency – social services. It is concern about this very practice of professionals believing that participation and responsibility end at the point of referral that Galpin and Hughes (2011) recognise. This concern is not in isolation as it is drawn from the findings of the Cornwall

and Isles of Scilly Safeguarding Adults Board, (2009) report further to the abuse of adults with a learning disability.

Whilst Smith and Anderson (2008) describe multidisciplinary work as a means of achieving consistent and effective outcomes for adults, the opportunity for this work to take place needs to be available. If *In Safe Hands* (NAW, 2000) infers that multidisciplinary decisions are good decisions, it offers little guidance as to how these should happen. Multidisciplinary decisions are unlikely to emerge without multidisciplinary discussion and recognition of potentially conflicting positions. Without this opportunity, social services and individual social workers will be working in isolation - a situation which Webb (2002) comments is unlikely to deliver good enough decisions for vulnerable adults.

The Social Services and Wellbeing (Wales) Act *2014* (Wales, 2014) proposes a duty for health and social services to collaborate to safeguard adults. At present, however, there is no indication that new sanctions or penalties will be introduced where agencies do not collaborate. Indeed, Jenkins et al. (2008) are cautious as to how genuine and effective working together in safeguarding is, or can be, achieved. This is unlikely to be assisted by a number of conflicting expectations and perceptions of how multi-professional roles and relationships should work to respond to adult abuse concerns.

4.3.3 Accountability

Despite concerns as to how the multidisciplinary team work together, interviews revealed that there was an expectation that multidisciplinary decisions would reveal good, accountable decisions. However, Savage and Moore (2004), who undertook an ethnographic study of a multidisciplinary health team, described that it is difficult to identify what accountability is. In their study accountability was referred to as a way of describing relationships between practitioners and patients, most usually this was associated to apportioning blame when something had gone wrong often with poor consequences for a patient. Conversely, in the same

research, Savage and Moore (2004) also identified that amongst their health colleague participants accountability was identified as taking responsibility for their own work and a prompt for improving practice which included taking responsibility for an action to take place.

Nurses and social workers in my study described that they perceived, if not expected, that multidisciplinary accountability provided collective, defensible action that may reduce or negate individual, professional responsibility and accountability. Social Worker 18, Nurse 13 and Social Worker 22 identified the value of seeking a multidisciplinary team view before raising a formal alert if they become aware of potential abuse:

> *…'Again I think it's, you know, I think the nice thing about safeguarding, in safeguarding is the shared accountability. To be honest in our team, it's like, we know they're nurses and all that, but we'll sit down and generally we'll discuss things'… (Social Worker 18).*

> *… 'straight away I would share it, any concerns at all you just you know you wouldn't work in isolation you would look for help and support'… (Nurse 13)*

> *… 'it's not my decision, but it's um, a multidisciplinary decision really. I know that, you know, my contribution would be, er, would be influential upon that, but really it would be a multidisciplinary decision, um, again for which you are accountable, but um, I think to be able to feel that you're not making that decision on your own is quite a good thing really'... (Social Worker 22).*

In these examples where Social Worker 18, Nurse 13 and Social Worker 22 are describing accessing support to assist to check out ideas – they appear to be using multidisciplinary conversations as peer support or informal supervision. At the discussion stage Social Worker 18 inaccurately perceives these early conversations as sharing accountability. Until a decision about the action that is required to respond to the potential abuse that they have identified, there is no sharing of accountability. The value of

these peer support conversations is in exploring what action is appropriate to secure the best possible outcome for the adult they are discussing. As Nurse 13 identifies, this conversation is for help and support so that decisions are not made in isolation, or at least take consideration of another view. Whilst valuable and valued, these conversations are not part of the recognised adult protection process although they may influence nurse and social worker decision making about the identification of abuse.

In addition to peer support, Nurse 1 described that in the CLDT in which they worked weekly meetings with the co-located social services team took place. These were referred to as multidisciplinary team meetings and were intended to be an arena to discuss significant events and adults, known to both the nursing and social work team. These did not happen in all CLDTs and the extent to which it was an arena to discuss individual adults or adult protection concerns varied. Nurse 1 identified this as a problem solving and accountability sharing arena, explaining how they would use this to respond to potential abuse recognised on a home visit:

> *…'I wouldn't take that accountability alone I would bring that back to our [MDTs] unless there is a clear serious (incident)' (Nurse 1).*

Where the risk was discussed and recognised in the team multidisciplinary meeting, a recommendation was usually made whether to raise a formal adult protection alert. Whilst Nurse 1 considers that this is a form of shared decision making or collective responsibility that improves accountability, it has the potential to delay a decision being made. Nurse 1 identifies that whilst feeling confident and competent to identify and respond to a *clear serious incident* (however defined) other incidents of potential abuse can potentially wait until the next multidisciplinary team meeting where decisions can be made with collective responsibility. Until that next multidisciplinary team meeting takes place, and unless other action is taken, Nurse 1 is accountable, whether they realise it or not for no adult protection alert being raised. In itself this decision to take no adult

protection action until a team meeting is held is an assessment and decision about the urgency of the identified abuse. Lukes (2005) advises that non-decision making can have powerful consequences, he identifies that, counter intuitively, decisions in relation to higher risk situations are frequently avoided with more assertive decision-making limited to less controversial decisions.

The perception of participants in this study is not necessarily that multidisciplinary decisions are good decisions, but that they are decisions with shared accountability. Collective decisions were considered to lead to better decisions about risk, even when a delay obtaining this may expose an adult to an extended risk of abuse. The selective code *my decision* features as an emerging finding. The point at which a practitioner makes a decision is not always clear as it has the potential to move around and between, partner agencies, before a decision whether to take adult protection is made. Whether sharing decisions with a number of professions minimises risk for the adult with a learning disability or instead supports the individual practitioner to feel supported, requires further discussion. Participants have identified that collective decision- making supports individual accountability.

4.3.4 Individual accountability

In describing their expectations of collective responsibility/accountability participants also reflected upon where they felt that their own individual accountability started and ended. Participants described that raising an adult protection alert offered protection to themselves as well as (or potentially instead of) the vulnerable adult. Raising an alert, was associated with erring on the side of caution, frequently regardless of the assessment of risk that had been undertaken at an early stage.

> *…'Um, personally I feel safeguarded by the process; Yes I would say it's a safety net'… (Nurse 2)*

…'I think everybody's really defensive about their practice, and about worrying about, you know, oh, you can't take any risk, nobody has any risk, you know?... defensive of their own practice, of, of, of worrying about having a finger pointed at them that they did something wrong, or of being accused, or being lax, or, because they didn't go in with a, you know, a straightjacket on the person.'…(Social Worker 12)

...'it shouldn't do (influence my decision) I know and that's when I think hmm, who am I doing it is it mine or am I just minding my back?'… (Social Worker 11)

... 'in supervision you need to make sure that you document that you need to make sure that you talk to the person and document that we have had a discussion so if something comes back you are not on your own because obviously we have discussed it and made recommendations'… (Social Worker 16)

Only social workers in the study expressed concern at making a *wrong decision* or missing potential abuse and perceived that the accountability for this would rest with them as an individual. Nurses, conversely identified more strongly with the earlier commentary that both the expectation and perception of their involvement is that responsibility rests with the extended multidisciplinary team, usually with social services colleagues. The relationship between participants and managers from both social services and health emerged as critical to the way that decisions within multidisciplinary decisions were made and is explored in detail in the following chapter.

The reasons for social work participants having more acute views of personal accountability are unclear; potentially social workers were aware of criticisms that social services have received in child abuse inquiries or had a more developed sense of personal ownership of adult protection practice as employees of the lead organisation for adult safeguarding. Social Worker 17 clarifies that it is their expectation that individual practitioners exercise professional judgement as to when an adult

protection alert is needed, involving social services further (only) once formal procedures are identified, as relevant. Social Worker 17 summarised this responsibility:

> … *'Well we are all responsible, we all have responsibility in our different roles, whether you are a support worker or even an unpaid volunteer, before it is raised as a safeguarding issue you have got accountability and a duty of care'… (Social Worker 17*)

4.3.5 Summary

Expectations and perceptions of how adult protection practice should work and how professionals should fulfil their responsibilities, heavily influenced participant experience. How nurse and social work participants expected the adult protection *official line* to apply to practice varied greatly. Personal beliefs, the organisation that they were employed by and the characteristics of and priorities the CLDT that they were affiliated to were all identified as contributing to the decision making practice that had developed.

Individual participants also identified and tolerated adult protection risk differently. Social workers more often sought immediate advice and peer support for a query before reaching a decision for which they were individual responsible.

Whilst nurses also have peer conversations, there was a greater motivation towards shared responsibility and sharing accountability in a team forum. The balance between taking immediate action and delaying a decision in order to have a multidisciplinary opinion was described by one nurse participant, but no conflict between the two positions were identified. The lack of urgency of this action is in contrast to that expressed by social workers, who predominately identified that decision could not, and should not be. delayed. Social workers expressed that they identified with a personal responsibility to identify abuse and expressed concerns about overlooking or missing abuse.

Nurses, conversely had greater confidence that sharing dilemmas reduced the personal responsibility.

Using the filters and motivations identified in the category *the official line* and the category *expectations and perceptions,* some adult protection concerns are identified as needing to be referred into the adult protection process. The concerns that are not referred to the adult protection point are instead supported by non-adult protection process actions, which are discussed next.

4.4 Initial findings – Non vulnerable adult options

When staff raise an adult protection alert, they initiate an adult protection response that the guidance *In Safe Hands* (NAW, 2000) introduced and for which the *All–Wales Interim Policy and Procedures* (SSIA, 2010) provides more detailed process guidance. This section focuses upon how nurses and social workers arrive at the decision not to use the adult protection process and what alternatives they identify as appropriate.

4.4.1 Non vulnerable adult process options: relational map

Figure 4.4 illustrates the links between emerging themes for non-vulnerable adult options. The relational map is the product of refining and re-working the data through a series of initial, axial and selective codes. Table 4.3 is an example of how these contributed towards the recognition of non-vulnerable adult options as a category.

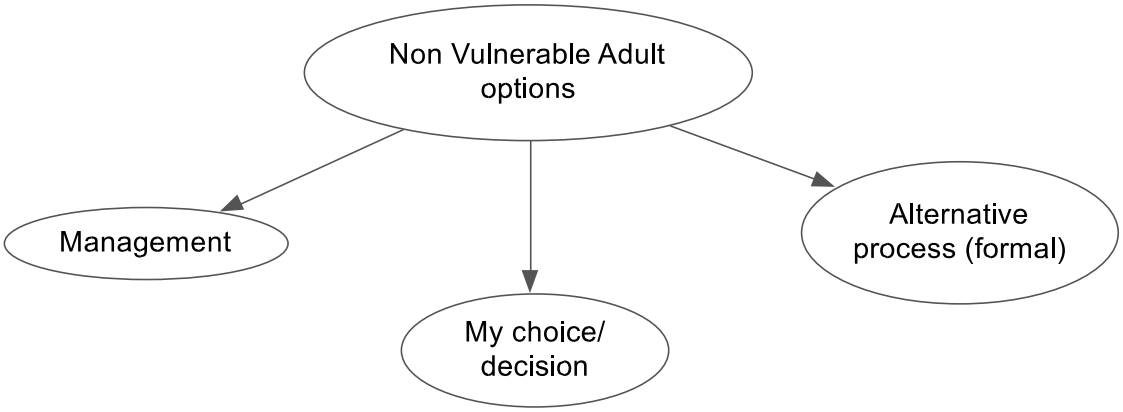


Figure 4.4 Relational map – Non vulnerable protection options.

Initial codes	Selective codes	Category
Quality and poor practice, quality assurance, provider concerns, staffing, Police, advocacy, choice, Mental Health Act, satisfaction with VA process.	Alternative process (formal)	Non vulnerable adult action
Relationships (family) (manager) knowledge of individual, VA as last resort.	My choice/decision	
Manager, confidence, overruling- a person's wishes, being overruled.	Management	

Table 4.4. Coding themes contributing to the identification of key relations.

4.4.2 Alternative processes

Where staff identified that alternative action to the adult protection process was required this was usually for one reason. That is when an alternative process or action was considered to be more appropriate and effective. Participants identified that in some circumstances there were alternative measures available that they considered to be preferable, or more appropriate to use than to use the adult protection procedures. Incidents

that may be criminal were identified as more relevant to police procedures whilst other incidents that related to provider concerns might be directed towards health or social services internal quality assurance processes.

4.4.3 Alternative action: criminal/police action

Although a criminal incident may also have caused significant harm and can be considered an adult protection alert, participants were more likely to direct the adult to the police in the first instance. Three reasons were identified by participants for the police being the most appropriate agency to take the lead:

- The type of abuse/incident that had occurred
- A criminal incident had been identified and there was a potential for criminal prosecution
- Resources

The type of abuse (rather than assessment of the person's vulnerability and impact of the incident upon them) and the incident itself was expressed as an indicator of the need for police involvement. This mirrors existing research where the type of abuse has been recognised to be a key indicator of what action was initiated. Jenkins, Davies and Northway (2008) and Northway and Jenkins (2013) identified that staff were very clear that action was required if physical or sexual abuse had taken place. As Social Worker 8 recognised, physical abuse was more likely to be associated to a criminal incident:

> *… 'It would absolutely depend on what the incident was. If somebody has been swiped over the head with a bottle you're going in there with the police'…* (Social Worker 8)

The relationship with police and success of working with police varied across the Local Authority areas with one Local Authority, identifying particularly strong working links and practice with the police. Regardless of this working relationship, a need to work with the police to achieve a good

outcome for a vulnerable adult was identified. Ensuring a good outcome for potential criminal matters was identified as securing the involvement of the police, not necessarily a later prosecution:

> … *'I mean it all depends, if it is a criminal investigation, you've got to decide that, haven't you, because if it's a criminal investigation'…* (Social Worker 12)

Whilst police support and intervention is neither expressly intended for, nor limited to, vulnerable adults, accessing it was viewed as part of the challenge of assessing vulnerability. Whilst a criminal incident can be reported to the police by any individual, a vulnerable adult in the definition of *In Safe Hands* (NAW, 2000) who is unable to protect his or herself from harm or abuse, would require this action to be taken on their behalf. Where an adult was able to contact the police for support themselves they may be excluded from also being considered a vulnerable adult. This had led to some confusion as to when and how the criminal process and the adult protection process joined.

The *In Safe Hands* (NAW, 2000) guidance does not preclude support from both the criminal justice and adult protection systems but police action is likely to predominate. Social Worker 17 noted, confidently, that people who could not raise a complaint to the police should be also be supported by the vulnerable adult process. Inability to access police support was viewed almost as an access criterion for support to be identified, be it through the vulnerable adult process or Mental Capacity Act 2005 (HMSO, 2005):

> … *'I have got my head around capacity issues, especially for people who are physically vulnerable and for the people who can make a police complaint'…* (Social Worker 17)

Whilst criminal and adult protection processes are not exclusive; Shearlock and Cambridge (2009) describe the difficulty of using the criminal justice process to respond to adult abuse. They reflect upon the high threshold of

evidence required for criminal prosecutions and that this is linked to realistic possibility of prosecution. Further, in criminal proceedings, the requirement for evidence to indicate responsibility 'beyond reasonable doubt' was considered a barrier to police taking on a case which may result in an incident of abuse commencing in the criminal system but subsequently resulting on no action. Reliance upon the criminal justice process to support a vulnerable adult may mean that wider patterns of risk not related to the criminal incident are overlooked. As a criterion for accessing the criminal justice system, the lower threshold of adult protection outcomes being 'on the balance of probability' was not considered consistently compatible with the police priority of securing a conviction. As Shearlock and Cambridge (2009) indicate, the police may wish to use their resources where there is a greater chance of criminal conviction. Walker and Walker (1998) identified that adults with a learning disability were likely to experience persistent low level crime, below the criminal test of 'beyond reasonable doubt' before a more serious abuse takes place. This, joined to a recognition in the same study that reports by, and on behalf of, adults with a learning disability, were not taken seriously (Walker and Walker, 1998) This has the possibility of denying access to justice to vulnerable adults, or relying on information gained during an adult protection investigation to demonstrate the need for the police decision to be reviewed.

In one Local Authority Social Worker 17 identified that wherever possible the police were invited to pursue adult protection cases as an alternative to the Local Authority. Discussing this point directly, Social Worker 17 explained:

> *… 'If we say that has to go through POVA that would just be such a drain on the resources that we have'…* (Social Worker 17)

The worker was employed in a geographical area where a good working relationship with the police was noted, with their comment indicating that police involvement could reduce duplication between the police and

safeguarding processes. They are not necessarily exclusive processes and opportunities to support a vulnerable adult appropriately may be missed if either criminal or adult protection processes are relied upon in isolation.

Clear ownership of the process at each stage is necessary to avoid confusion and missing opportunities for criminal prosecution.

4.4.4 Alternative action: poor practice

Poor practice or concerns about provision of services were a source of concern for some workers as these concerns had the potential to be, or to become, abuse. Participants identified that an alternative to adult protection was that of using quality assurance and provider measures or commissioning processes to respond to shortcomings in the perceived standard of care. Whether this was a conscious, informed decision and genuinely an alternative to use of adult protection procedures was discussed. Participants expressed confusion as to when it was most appropriate to use quality assurance or provider concern measures rather than adult protection measures. Based in the community CLDT members were predominately commenting on services that were themselves purchased or commissioned by the Local Authority. Social Worker 6 offered their understanding of this in the Local Authority in which she was employed:

> *… 'In the beginning I did find that really hard, what's a provider issue, and what's a, what's a POVA? ...and it was felt that it was a provider issue rather than a POVA concern, and I guess the reasoning was that the service user didn't come to any harm'…*
> (Social Worker 6)

Social Worker 6 identifies that significant harm – the *In Safe Hands* (NAW, 2000) description of a threshold of abuse denotes whether an incident or adult's experience constitutes abuse. As previously acknowledged, defining significant harm or that point at which significant harm occurs, is

not straightforward and the same dilemmas exists where the quality of care provided has not met expectation. Giordano and Street (2009) acknowledge that the safeguarding process and the provision of quality care are intertwined, and that the identification of which is the most appropriate at a particular time is hard to identify. The confusion of this join between case management and adult protection is reflected upon by Social Worker 12 and Nurse 4:

> … *'Particularly about that early stage, particularly about that bit, does this go into adult protection, does it stay in care management – that join…'* (Social Worker 12)

Nurse 4 referred to this difficulty acknowledging that poor practice can creep up steadily resulting in the identification of abuse:

> … *'Yes, sometimes if you go to an organization they can say that was just a one off, just a blip. But sometimes there are a number of blips and then you think right there have been too many single incidents so you raise a POVA then'…* (Nurse 4)

Whilst it is possible for services in the community to be commissioned by the NHS or Social Services, the services that nurses and social workers in CLDTs are referring to are predominately commissioned by a Local Authority. From the comment of Nurse 4 it appears that initial shortcomings were not raised with the provider or the Local Authority commissioner of the service and instead it was not until these concerns escalated that Nurse 4 decided to take action. When Nurse 4 did identify concerns about an escalation of poor practice, they identified that their experience had been positive because adult protection procedures were not initiated and that instead:

> … *'Outcome (improvement) measures were put in place to improve practice'…* (Nurse 4)

The CSSIW (2010) National Inspection of Adult Protection report identified that the application of this threshold between poor practice and abuse varied throughout Wales. Some Local Authorities, it concluded, were unexpectedly quick to use adult protection procedures rather than alternatives whilst some managed risks more appropriate to adult protection within quality assurance and casework mechanisms. The thresholds guidance in *All–Wales Adult Protection Policy and Procedures interim guidance* (SSIA, 2010) advises that a one-off incident of poor practice may not constitute abuse whereas the same incident repeated over time may do. This is of relevance as the same document (SSIA, 2010) outlines that the impact of abuse is personal to the adult and that this should determine the significance of harm rather than the nature of the incident or a practitioner. Participants who had had a positive experience of using the provider quality assurance process expressed that this would be their preference, even where significant harm had been identified and use of the adult protection procedures would be appropriate:

> …I sometimes think it is a bit over the top to look at it through safeguarding because that takes us out of the office for sometimes half a day writing up where that time could be spent just sitting down with providers and reviewing guidelines which is all you are doing through POVA anyway... (Social Worker, 17)

The priority for participants was improving the situation for adults, whether the provider process or adult protection was of little concern to them. What was valued was an open, honest and timely approach that provided the opportunity to identify and challenge practice that appeared unusual or unsafe. Nurse 4 was able to give the example of feedback from the visit of a student nurse she was supporting:

> *…'Students are good as they will question things with you if they have been for a day to day centre or to a local nursing home and they come back and question practice... I don't want to say alarms, is this ok? Is this standard practice?'(*Nurse 4)

As Giordano and Street (2009) discuss, the purchase of services by Local Authorities creates a different or uneven relationship with the service provider. It does not however negate the responsibility of individual practitioners including Local Authority social workers to raise concerns where they are aware of them. Although internal social services processes to monitor and improve the quality of services available and adult protection action are by no means mutually exclusive the decision that a provider concern should be managed within adult protection, attracted strong comment. The equity of these decisions was also challenged by staff especially where the individual practitioner had disagreed. Some practitioners felt that some providers of services (especially those internal to social services) could be favoured over private companies delivering services contracted out by social services and that the role of purchaser and provider of care arrangements could be in conflict with the safeguarding responsibilities of the Local Authority. Social Worker 3 expressed that it was their belief that the Local Authority protected it's directly employed staff (
e.g. home carers or day centre staff) from being referred into the safeguarding process. Social Worker 3 identified that quality improvement methods were deliberately chosen in these circumstances rather than adult protection procedure which was viewed as inequitable and unfair:

> … *'We're not treating our own staff as we would external staff'…*
> (Social Worker 3)

The use of adult protection procedures with care providers was not always considered proportionate. Nurse 1 also reflected upon initiating adult protection procedures with providers that it could be viewed as a:

> … *'punitive measure rather than seeing it as a way of bettering practices'…*(Nurse 1).

Again, Social Worker 3 added to their comments that the use of the adult protection process could feel heavy handed. They recalled that when they had sought advice as to how to respond to concerns about quality, they had been guided towards a response that appeared punitive to Social Worker 3. Even before consideration was made as to whether significant harm had occurred, the worker stated that they were under the impression that senior staff had been waiting for an opportunity to take action. Social Worker 3 described the direction they were given and reflected upon whether a safeguarding alert was also used as a sanction:

> …*'Somebody needs to be hammered with this, someone needs to be held to account. Wanting someone to blame and a head to roll and the only way to do that was via a POVA. POVA [is used] inappropriately to bollock someone with and that's when you get in discussion about thresholds'…* (Social Worker 3)

The use of a quality assurance process instead of adult protection procedures was not unique to the Local Authority. In a report from Health Inspectorate Wales (HIW, 2010) NHS organisations were noted to use the internal process of clinical incident reporting excessively and often inappropriately where the safeguarding process would have been a more appropriate response. The motivations for not using the adult protection process were not clarified in the report. The report did, however, indicate that clinical incident reporting may undervalue the significant harm that an adult has experienced in NHS care.

4.4.5 Alternative action: resources

Scarcity of safeguarding resources and personnel to manage the adult protection process was raised as a prompt to take alternative action to raising an adult protection. Participants identified that staffing, and availability of staff, to take on roles within the adult protection process may influence the direction of a concern. This was noted uniquely by Local

Authority staff who, as employees as the lead agency for safeguarding, are more likely to be aware of these internal staffing pressures than health partners raising an adult protection alert. When staffing resources were stretched, Social Worker 7 described that it was their perception that the levels of safeguarding risk that the specialist adult protection team accepted as adult protection concerns, also increased:

> …(the) *'POVA team were completely inundated, and a lot of stuff was being sent back'…*(Social Worker 7).

Participants identified that being part of the adult protection process as care manager or DLM was time consuming. Whilst this was not a stated reason to avoid initiation of adult protection procedures, staff recognised that the time adult protection work required had the potential to be burdensome as part of an existing role:

> *… 'We just seem to be really busy on them at the moment. Vulnerable adults take up, like, about 80% of your time a lot of the time'…* (Social Worker 6).

What is clear from these initial findings is that practitioners value or expect direction and guidance when considering whether an incident is abuse and whether to raise an alert. This assists nurses and social workers to explore significant harm, the impact of the abuse or incident upon the individual and formulate a rationale as to whether an incident requires an adult protection response or an alternative response. Whilst participants did not always agree with the rationale that they were given by colleagues, safeguarding specialists or managers, to seek an alternative response to that of the adult protection process it was largely unchallenged. Given the identification of this experience, the extent to which individual nurses and social workers make their own decision requires greater discussion.

4.5.6 Alternative action: relationships

Practitioners identified that supporting an adult over an extended period of time allowed a relationship to form. Where participants described a strong relationship with the family of an adult with a learning disability, they were frequently more reluctant to initiate an adult protection alert, preferring instead to take alternative action or no action at all. A strong relationship with the family of a service user was usually viewed positively (by participants) although not without limits. The limits upon this relationship are noted by one participant:

> … '*I mean I think that obviously there's advantages in that you, you get to know people quite well and you know, but I think it's important that when you work with people on a long-term basis that there's that professional line that you don't cross'…* (Social Worker 12)

Nurse 24 recognised the complexity of building relationships with the family of adults:

> *…'It's complicated though, cos you've got to have a kind of working relationship with people, you know, and there's got to be an element of trust, you've got to develop a rapport to an extent, but obviously you have to stand back on occasions and think, am I compromising my practice here, am I not advocating on a person's best behalf, because you can get drawn in with families'…* (Nurse 24)

Practitioners were aware that where an adult protection referral may be appropriate it had the potential to damage relationships. Nurse 23 described their relief that they had taken advice from Social Services and did not have to raise an adult protection alert themselves but that the risks were instead managed with advice and guidance from social services:

> *…'So, on some occasions like that we can see it's a relief because we don't want to see people being put through the process unnecessarily, um, and damaging relationships within families or their care teams or whatever'...* (Nurse 23)

The view was not only expressed by nurses, Social Worker 12 commented :

> … *'I think sometimes people press the big red button before they really need to, and I think that can do more damage than good to relationships when you're managing them'...* (Social Worker 12).

Participants summarised that using the adult protection process was a last resort especially where they had good knowledge of individuals and their families. The need to raise an adult protection referral may be perceived by participants as a failure of other methods of support to protect the adult from harm. Bowler and Nash (2014) identify that the relationship between a learning disability nurse and the person in their care is a professional one, based upon trust, respect and appropriate use of power. In situations of potential adult abuse, a practitioner needs to exercise judgement about the appropriate use of their power and responsibilities, which may include making a decision that will damage their own personal relationship with the vulnerable adult or their family.

In the practitioner examples staff discussed their reluctance to use their power to raise an adult protection alert. Reticence to raise adult protection concerns where staff identified a good relationship with service users, or more usually, the family of service users emerged as a significant influence upon whether an adult protection referral was raised. In so doing they were exercising both their professional judgement and power by not raising an alert. Lovell and Skellern (2013) discuss that similar dilemmas about relationships were identified when reporting violence against staff by adults with a learning disability. Nurses in particular were noted to under- report violence compared to other NHS staff, and referred to a therapeutic relationship between themselves and adults with a learning disability for not doing so. Whether staff would purposely avoid conversations that had the potential to disclose adult abuse, was explored in later interviews. Social Worker 21 added:

> …' *in relation to learning disabilities, families throw a protective cloak around the service users so on times it's very difficult because people, they show you the door, say thank you but no thank you. So on times it's difficult to address some potential issues especially around financial*

abuse. It's very much of a land-mine especially for a social worker within learning disabilities'... (Social Worker 21)

Here again, type of abuse also appears significant to Social Worker 21 who appears to have risk assessed that the possibility of asking further questions about finances may limit or make access to the adult problematic. Whether the discussion of finances is permanently excluded from conversation is unclear. Social Worker 21 does not make clear if they will return to this trigger in future conversations but instead identifies that their perception is that working with adults with a learning disability is different from working with other adults. If staff believe that there are significant differences that are specific to working with adults with a learning disability and that usual triggers for abuse do not apply, there is the potential that CLDT staff could deny, if not condone abuse. Nurse 2 explained that when they considered potential abuse and appropriate risk responses that their decision:

… 'depends on the history and your involvement in the length of time and you maybe more understanding of the circumstances'… (Nurse 2)

Nurses and social workers identified that knowledge of the adult's individual and family circumstances influenced their decision whether or not to raise an adult protection alert. Where it was necessary to do so, and the practitioner knew the adults and their family well, it was almost always as a last resort.

…'*I think personally I would always (hesitate to make a referral) that's always going to the absolute last resort because families are going to be so (upset)...*(Social Worker 3)

Holland (2012) identifies that adults need to be aware of the relationship and boundaries between staff, service users and their families. Where these boundaries change Holland, Allen and Cooper (2013) consider that

what is allowed in the relationship is at risk of becoming ambiguous with the possibility that potential that abuse is tolerated. A Canadian publication of guidelines of professional nursing behaviour produced by the College and Association of Alberta (2011) suggested that professional behaviour could be placed on a continuum between being under and over involved. Between these, a *zone of helpfulness* in the middle, in which usual interaction is effective and safe, was identified. Bowler and Nash (2014) identify two characteristics that may be especially relevant to my study:

- the influence of personality over being clear on the needs of the person
- where a professional approach or response may vary between service users.

This is not to undervalue individuality or to minimise where professional discretion is required, simply to be alert to the potential that it may indicate a blurring of professional and personal boundaries.

4.4.7 Summary

Nurses and social workers identified that alternatives to the adult protection process were available which they considered to be preferable. Initial findings also revealed that alternative procedures and process were valued and used by practitioners. This may be because alternatives were viewed as more effective or more likely to deliver positive outcomes for vulnerable adults – such as a criminal process. Quicker options than using the adult protection process such as using quality assurance and commissioning processes, were identified as attractive to participants. Equally, participants did not recognise the decision to raise an adult protection referral as theirs to make although they were at ease making decisions to take non adult protection action.

Emerging as significant in this category is the extent to which nurses and social workers have, and are happy to take, the opportunity to make their own, independent decisions and have confidence in them. The confidence and competence is the next category.

4.5 Initial findings: confidence and competence

Competence in this study is the ability to identify and respond to abuse appropriately. Confidence emerged from participants as a significant influence upon their willingness to commit to making an individual decision to respond to abuse, even if they felt (and their colleagues considered them to be) competent to do so. Through a process of negotiation of risks and circumstances, the considerations of nurses and social workers indicated how competence to understand key issues and their confidence to respond to them, informed adult protection decision making. Applying both confidence and competence to a practice dilemma revealed a series of frequent actions taken by nurses or social worker participants.

The relational map is the product of refining and re-working the data through a series of initial, axial and selective codes. Table 4.4 demonstrates how the characteristics of this category were identified.

4.5.1 Confidence and competence: relational map

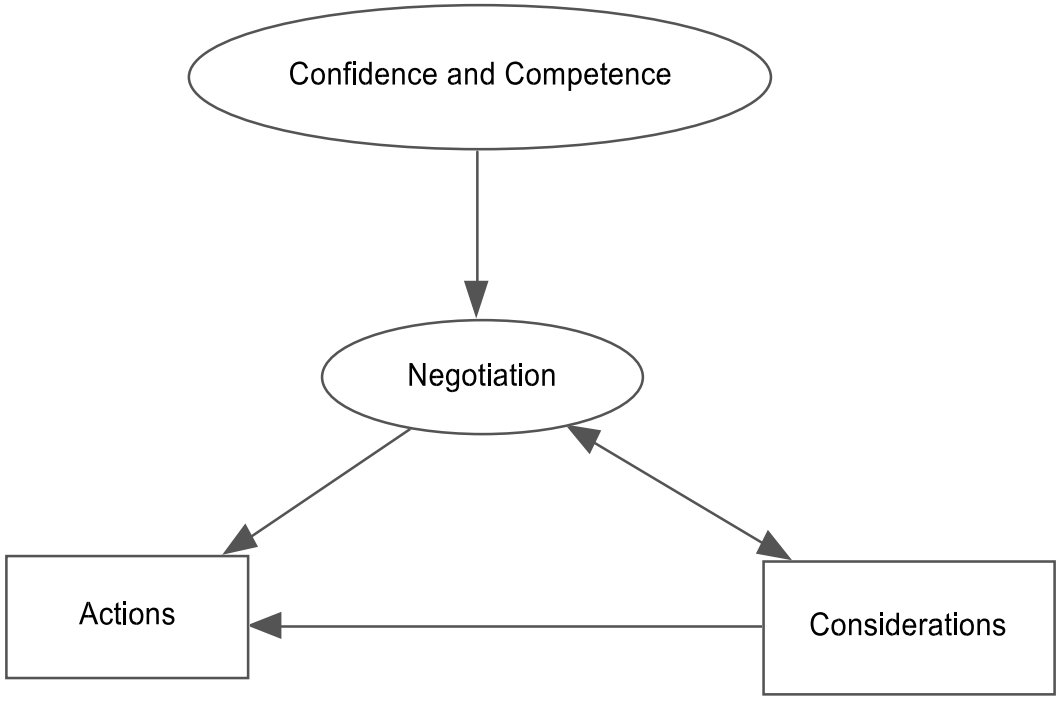


Figure 4.5 Relational map: Confidence and competence.

Initial codes	Selective codes	Category
Negotiations, caution, comfort, experience, doubt, confidence	Considerations	Confidence and competence
Manager, accountability, supervision (informal and informal), Safeguarding specialists, DLM, workload	Actions	

Table 4.4 Coding themes contributing to the identification of key relations

4.5.2 Confidence and competence: considerations

Social workers and nurses identified that their own practice experience contributed to their decision making. Both confidence and competence were characteristics described as being gained over time. Social Worker 16 discussed how their awareness of policy and guidance combined with their practice experience to result in a competent decision:

> … *'Everybody has got background, everybody has got experiences, everybody does practice; you know so it all impacts… I might feel like that but what am I basing that feeling on and have the picture in front of me is this and that is why I need to be risk assessing'…* (Social Worker 16)

Acknowledging, that whilst increased experience does not always indicate increased competence, experience was identified as making a major contribution to both the ability to identify abuse and the confidence to respond to it. A gut feeling or intuition was identified as an indicator of potential of abuse for nurses and social workers:

> … *'So you know, you get a gut feeling as well'…* (Social Worker 21)

> … *'Things like that tell you, you know, gut feelings' …* (Social Worker 12)

…'your intuition, your experience would kick in'… (Nurse 9)

Walker and Ward (2013) acknowledge that the use of intuition as a skill by nurses may appear a spontaneous and unplanned response. However, Walker and Ward 2013 offer that the most intuitive nurses are usually the most experienced, possibly because they can critically reflect upon their previous experiences and apply these to their practice.

Social Worker 12 clarified what contributes to this gut feeling; identifying that part of their role is about being alert to cues and characteristics that may indicate potential abuse:

> *… 'if you went into a family and they're all looking very nice and, you know, doing things and the client isn't, and you know, er, or if the client can't do things with carers because they have no money and the parents are not releasing it. Just the way the care staff talk about people, you know, um, the smell of places, it's all, it's all kind of linked'…* (Social Worker 12).

O' Sullivan (2005) describes this style of practice not as a gut feeling but instead as *practice wisdom;* a reference to critical, accountable and knowledge-based practice that remains flexible and creative. Practice wisdom for O'Sullivan (2005) is the intuitive and skilled use of practice knowledge and experience. Participants identified that not only was this practice wisdom desirable but that when combined with local knowledge it was increasingly present or powerful in practice decisions. Nurse 24 described that the practice knowledge, in particular knowledge acquired about families the team over time, contributed to their decisions:

> *…'Some of us have been around quite a long time, and that's a good thing in a way 'cause you can draw on past experiences, and perhaps it leads to a bit of confidence in your practice'…* (Nurse 24)

It is not just individual social work and nurse practitioner colleagues that are identified as contributing to their own adult protection decision making, but the wider experience within the CLDT is also accepted as collective practice wisdom: *…'er, some members of the team have worked, er, with particular individuals for many years, um, I tend to rely quite heavily on their past experience'…'I think because we've worked with people over many years, I er, especially the Team Manager here has got huge experience and knows all the service users and their families, and er, so I tend to rely quite heavily on that really'...* (Social Worker 22)

In this example Social Worker 22 acknowledges that it is not only the collective knowledge of colleagues that is essential to their decision making but that historic awareness of families by colleagues or their manager (who may not have seen the person for some time) was also relevant. This view was not without limits as Social Worker 22 went on to raise; past experience, they recognised, was not a reliable indicator that the current situation has the same risks and that the same response was always appropriate as over familiarity could obscure the identification of changing risks:

> *…'because people have had experience over many years, it can sometimes cloud the issues, it can sometimes make things clearer as well, but it's making that judgment, isn't it?'…* (Social Worker 22)

Whilst individual workers may feel confident that a past team experience may contribute to a collective intuition. Walker and Ward (2013) identify that caution for practitioners not to be over-confident is desirable. This over confidence could be derived from several sources including out of date or inaccurate beliefs about historic risks or knowledge of the situation. The demographic information in table 3.4 demonstrates that participants in my study have significant experience of working within a CLDT, knowledge

about risk has been acquired over a number of years. For newer members of the CLDT who do not have the same history within teams and with service users and their families, the acquisition of knowledge and collective knowledge is likely to be different. Whilst these newer members of staff are socialised into the CLDT by team members, Walker and Ward (2013) clarify that less experienced practitioners are more likely to rely upon policy and guidance whilst more experienced colleagues rely upon intuition. Initial concerns about abuse that emerge may need to be constantly challenged and re-assessed to remain relevant. In working in this way, nurses and social workers are constantly renegotiating and redefining how they understand risks, how they are evaluated and the response that they require.

4.5.3 Confidence in individual competence

Participants identified that they felt confident when they applied policy and guidance to their practice and that they were comfortable with the decision that they had arrived at. Social Worker 7 commented, that they could confidently identify and apply the threshold of 'significant harm' derived from the *In Safe Hands* (NAW, 2000) guidance to practice:

> '…*(I) would feel confident enough to say, no, that's not significant harm...I'm quite confident that yes, this is, this is definitely a VA... I'm very confident that I know that that is not significant harm'...* (Social Worker 7)

This confidence is counter to some of the reticence already expressed by participants; both to identify significant harm or abuse individually and to have the confidence to advocate for or defend their decision. That is not to suggest, as Social Worker 22 later clarifies, that this confidence is without limits and that that knowing that assistance is available adds to a broader confidence to practice. Practitioners identified that confidence in their own decision-making and being at ease with this decision was influenced by confidence in their own ability and experience. Social Worker

6 described their experience in balancing confidence in individual practice and arriving at clear, accountable, defensible practice decisions:

> *...'I think at the beginning, it definitely was an awful lot, sort of thinking, if I don't say the right thing it will come back on me'…* (Social Worker 6)

> *…'Um, yeah, it's something, (accountability for decisions) I think that…makes me, makes me quite nervous really'...*
> (Social Worker 22)

Nurse 25 develops the link between individual competence, confidence and the responsibilities of raising concerns about abuse:

> *…'I think again you have to have openness and transparency you know, I've been involved in a process, an incident in the past where what I say is, I will not apologise for this process it's here to protect people so you kind of use that language, you know, you have to be very clear'…*(Nurse 25)

Nurse 25 makes a clear link between confidence in their own practice and the need to be open and honest with adults and their families. The language used is consistent both with the principles of *In Safe Hands* (NAW, 2000) and the NMC code of professional practice in place at the time of data gathering (NMC, 2008). The comment demonstrates confidence both in making a decision and comfort with that decision. As much as confidence is a feature of arriving at a competent decision, doubt and caution also featured as influences in arriving at a decision:

> *… 'In my experience a lot of these things are not straightforward, they need a lot of thinking, and sometimes, as a practitioner, as you were saying, sitting on the sofa, you've got to think on your feet, then you've got to come back, reflect, maybe run it by somebody else, say mmm, this is my feeling, what do you think about that?'… (*Nurse 24)

> … *'I think, I think I probably would err on the side of caution, um, but that, but that it would be a difficult decision to come to really'...* (Social Worker 22)

Erring on the side of caution was identified as opening up and discussing a safeguarding dilemma to someone else. This might be through the peer support identified in previous sections, through the vulnerable adult process or through conversations with a manager. Whilst staff identified that they felt confident in their own ability to respond to abuse, no measure of the competence of that response has been explored in my research study. It is relevant to acknowledge that this section recognises confidence in individual competence, it does not necessarily align with the views expressed in the expectation and perception category where differences between the competence of multidisciplinary colleagues may be perceived.

Negotiating and considering potential adult protection dilemmas were framed by confidence and competence in individual decision making. These considerations then influenced what actions individual participants felt were appropriate to take.

Participants identified that competence referred not just to individual competence derived from the application of guidance and experience to potential abuse, but included knowing when to take action. Where individual practitioners were not confident to recommend the raising of an alert independently this was frequently because they sought further advice. Noting the patterns of seeking advice that have already emerged in this study, confidence in making a decision demonstrated a more complete picture of how this advice was gained. Figure 4.6 illustrates the sources of advice that nurses and social workers acknowledged and how these contribute to a pattern of escalation that moves decision making between professionals and around organisations :

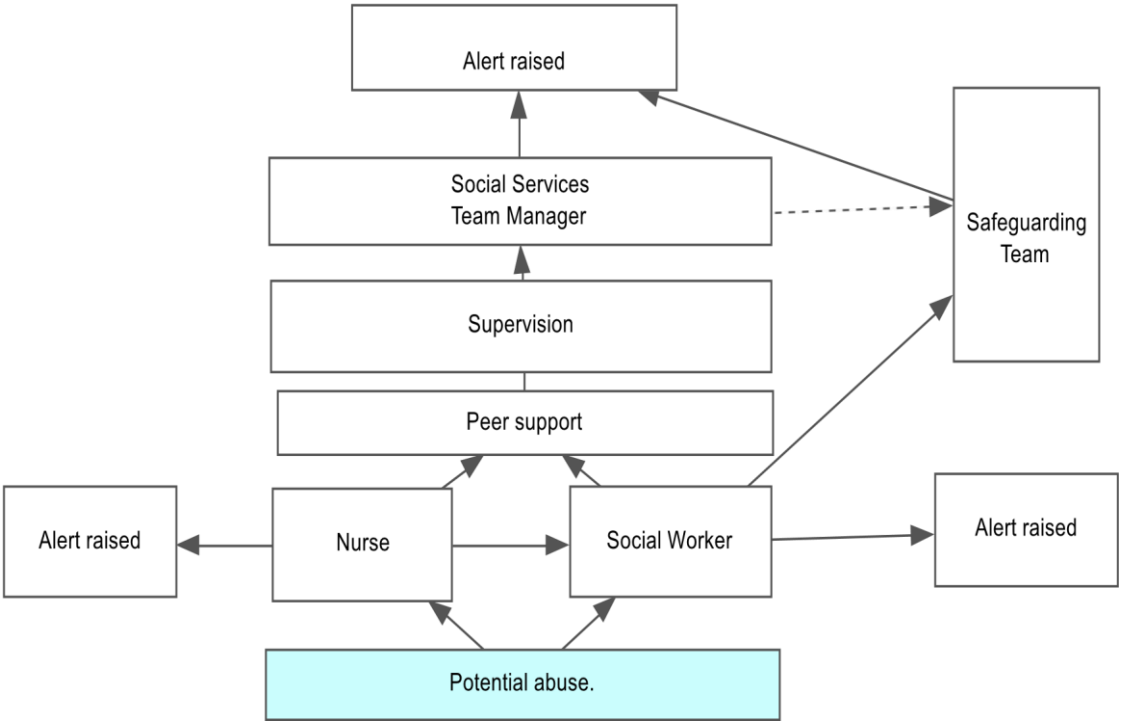


Figure 4.6 Escalation of concerns and seeking advice

Acknowledging that there are local custom and practices as to whether it is the practitioner or a Team Manager who has the responsibility to endorse or raise a referral, the decision to escalate a concern to another person is also influenced by the confidence and competence of individual nurses and social workers. Figure 4.6 illustrates the route by which concerns about abuse may be escalated by practitioners, should the practitioner not have the confidence to raise the concern immediately. Figure 4.6 includes recognition of how peer support and supervision (by Team Manager) as well as specialist safeguarding colleagues are sources of support. Usually this support includes an opportunity to discuss and validate concerns that a nurse or social worker may have. The significance of these sources of support is now explored.

4.5.4 Supervision and peer support

Seeking an opinion and talking a concern through featured throughout this study. Whilst this section is entitled confidence and competence, use of managers (usually Social Services managers) contributed to practitioners' experience and in turn to the decisions that they made. Colleagues and

managers were acknowledged to contribute to developing practitioner confidence and competence through support and supervision. This supervision, participants identified, could be formal or informal (including peer support) and an opportunity for challenge, reflection, development and, in some instances, reconciliation with the action taken (or not taken):

> *'…(if) we don't have concrete evidence of this, that and the other and you've just got to… but that's good supervision, it kind of pulls you back there which that's really important…I have clinical supervision bi-monthly but I have managerial supervision monthly (with my health team manager) I have peer supervision, I really value, I probably value that more than anything…'* (Nurse 25)

> *'…sometimes like I said with supervision maybe someone comes up with something and collectively think hold on a minute we need to look at that'…* (Social Worker 16)

Supervisors and practitioners identified that supervision also contributed to recording decisions and these could contribute to accountable decisions.

> *..(I) just tell people in supervision 'you need to make sure that you document that you talk to the person and document that we have had a discussion' so if something comes back you are not on your own because obviously we have discussed it and made recommendations'...* (Social Worker 17)

> *...'I think generally, what I've learnt from being in a team is if you discuss things in supervision, you…document your thought processes and stuff, you know, that's, you've done all you can really'...* (Social Worker 6)

Nurse 25 describes the value of informal peer supervision– possibly because it was available at the time of the dilemma – rather than waiting for formal supervision. The peers that Nurse 25 refers to are colleagues (both social work and nursing) that have similar day to day exposure to potential adult protection issues. Social Worker 16 who is also a supervisor of social work staff, adds that supervision can be a chance to re-visit adult

protection concerns or reflect upon situations and practice where an individual practitioner may not have identified an incident as potential abuse.

Supervision is identified as a check on the competence of the staff that they supervise. Writing in the American context Chihowski and Hughes (2008) suggest in their research that effective supervision makes a significant contribution to reducing (elder) abuse because it can place the potential of abuse permanently into the practice conversation. To be successful, however, this supervision conversation and reflection must be accompanied by other guidance and training to ensure that practice is challenged and develops. Chihowski and Hughes (2008) offer that not only is supervision about accountability, it should also be a genuinely open process that contributes to the prevention of abuse.

The role of Designated Lead Manager (DLM) was frequently referred to - a position that is identified in local policy and in the *All–Wales Interim Adult Protection Policy and Procedures (*SSIA, 2010) once an alert has been raised. Local differences in practice may also contribute to this (mis) understanding. In some CLDTs it was the practice of the CLDT that the Team Manager was required to undertake the role of DLM for adult protection concerns arising from their own team. In other CLDTs it was established and purposive practice that adult protection alerts that related to the CLDT were given to a DLM from an alternative team. Participants expressed that speaking with a Social Services Team Manager who also had a role as a DLM, was equivalent to speaking with a DLM formally in the adult protection process.

> *… 'the Team Manager here is the DLM for the team as well, so that would be, the first, the first person that you would speak to'…* (Social Worker 22)

Caution, if not lack of confidence is evident in the decision making of individual practitioner participants. It also emerged at all stages of the alert

raising process. Figure 4.5 illustrates that where a decision whether or not to raise an adult protection alert could not be reached even with the involvement of a Team Manager adult safeguarding specialist staff could be asked for an opinion.

4.5.5 Role of management

Staff consistently identified that managers had a considerable influence on their decision-making and their individual adult protection practice. This influence was usually described as positive by participants, either because it provided direction, shared responsibility or allowed or endorsed access into the adult protection process. The roles of manager advisor and gatekeeper to the adult protection process, were acknowledged by social workers and nursing staff. As advisors to staff who identify potential abuse the position of the social work Team Manager was respected both as a representative of seniority within the Local Authority and because they often had significant (usually local) practice experience. Participants acknowledged this advice:

> *…'I'd discuss it with my manager absolutely definitely, somebody with a lot more experience or senior practitioner whoever'…*(Social Worker 19).

> … '*If I am very unsure I will speak to my manager...'* (Social Worker 7)

> *… 'I'm a bit like that you know that I'm not very good at keeping things to myself if there's a little, if I'm not sure or indecisive or it's something I haven't come across, it's the first thing I do, and luckily we have a manager and a Team Manager, their doors are open and you can walk in and say I've got a problem or what do you think'…* (Social Worker 10)

Taking advice from managers emerged as a form of extended peer support in considering concerns that social work staff identified. Whilst this support frequently commenced as advice, it frequently became more than an

opportunity for staff to discuss concerns, emerging instead as a decision making arena. Participants identified that a social services manager, usually the CLDT Team Manager was the first point of contact:

> … *'I would probably, in my position, be both taking direction, sort of, from a wider team and my line manager'…* (Social Worker 6)

When nurses and social workers sought an opinion from a social services manager it did not emerge immediately as to whether this was for instruction whether to raise an adult protection alert or not, or an opportunity to add to critical reflection upon the situation. Later, more definitive identification of a manager as decision-maker emerged; not only did social work participants take direction from managers but they had experienced having their own views overruled by managers:

> … *'A manager from a different team may tell me that's a POVA, I've said no it's not, he or she has said yes it is, okay they're senior to me I'd better put a VA1[referral]. I've filled in a POVA because I've been told to by someone else again, because they've been senior to me it's been told to me that I had better complete it'…* (Social Worker 7).

> *'...so you'll have a discussion with them and then it might be agreed that it is POVA or it's not. Sometimes a decision is taken out of your hands...'* (Social Worker 11).

As registered social workers and registered nurses, the respective codes of conduct (now) (NMC, 2015, Care Council of Wales (CCW), 2015) apply to individual practitioners. Both codes of conduct recognise that individuals must exercise their own professional judgement. This rarely featured in the interviews with practitioners, even where the expectations of professional standards were acknowledged. This experience of managers making or overruling practitioner decisions challenges whether the individual practitioners are the decision-makers about whether an adult protection concern becomes a formal alert.

A difference emerged between health and social work practitioners with only social workers identifying being overruled by managers as a negative experience and source of frustration. Nurses comments here are few, with nurses seeking advice from managers far less a feature of interviews than for social workers. That is not to dismiss the role of managers in supporting nurses in arriving at decisions only that need to do so emerged less frequently. Where advice was required by a nurse from a manager, this was most likely to be a Social Services manager. The positional map in the discussion of emerging themes identifies and discusses this further (see table 5.5).

A pattern of moving decision-making has emerged during these initial findings, and relationship with managers as gatekeepers highlights this. There is broad agreement, or at least acknowledgement, that where adult protection concerns are noted they are most usually directed to social services for further consideration. This discussion is most likely to be endorsed or directed by Social Services managers. Whilst individual practitioners can raise concerns or make, or decline to make, adult protection referrals, doing so without the agreement of their own line manager emerged as unusual practice. This experience is significant in starting to understand individual decision making and accountability of decisions and who within organisations influences the decision of the nurses or social workers. Whilst managers are a significant influence upon nurses and social workers, staff with safeguarding specialist roles within the Local Authority were also identified as considerable.

4.5.6 Safeguarding specialist roles

Whilst the circumstances of an incident of potential abuse may direct or influence the outcome of the interaction with managers and safeguarding specialists the relationship between day to day practice and safeguarding practice featured in several interviews. Participant comments indicated that not only were day to day practice and safeguarding decisions not integrated but the presence of specialist safeguarding practitioners or teams

reinforced this view. Whilst this risks dividing accountability for adult protection decisions and has the potential to move decision making from the practitioner to safeguarding colleagues, it generated mixed views from participants. Social work participants had no strong consistent views as to whether this separation (perceived or actual) was universally positive or negative. Social Workers 15, 16, 17 and 20 shared their experiences of working with specialist safeguarding members of staff, and the benefits and challenges of this:

> '. *...or you could come away from a telephone conversation and think I have got to talk to my team manager about that, they usually say "discuss it with safeguarding", so you do that, and how they exactly work that remains a mystery'...*
> (Social Worker 17)

> '…*they'll have a side of caution, we often do, they'll just run it by safeguarding, just to be sure'...* (Social Worker 15)

> '…*I usually just ring up the safeguarding team, the POVA team just for a general inquiry for advice really; you know if something niggles you, phone them and if we, if there are any concerns then, we put in a VA1 into them…If there's something niggling you, you can discuss it there or straightaway with your manager, you know, meet with them and go through it for you're never quite sure...'*
> (Social Worker 20)

> … '*I do talk within supervision about safeguarding issues and then obviously if I think it is something that is over and above normal care management then I will say I think you need to speak to the Safeguarding Team regarding that and decide whether we need to put a VA1 in...'*(Social Worker 16)

The comments describe the relationship between individual practitioners in CLDTs with safeguarding units and that there is respect for the guidance offered. The comment of Social Worker 20 summarises that consultation with safeguarding specialists is both for practice guidance and to underwrite individual decision-making. Social Worker 8 summarises that

not only do they seek an opinion from safeguarding specialist staff, but that the decision as to whether an incident is defined as abuse is also expected to be made by safeguarding colleagues:

> … *'It's a really tough one. I wouldn't want to be the person who draws the line in the sand to be honest'...* (Social Worker 8)

4.5.7 Summary

There is potential conflict between the confidence that practitioners expressed in their own decision-making and caution that was noted by the need to seek further advice from their own managers and potentially also safeguarding staff. Social Worker 16 describes that some adult protection decisions are outside of the skill and experience available within the CLDT (including themselves and their line or team manager) and that these require a review and opinion by a member of safeguarding staff.

Whilst a social worker or nurse may consider themselves to be competent to make a decision, the involvement of a manager or safeguarding specialist indicates that there may be a lack of confidence to carry out the decision. Where practitioners and Team Managers were unclear or cautious about a decision they were likely to direct the concern to safeguarding colleagues.

> … *'But it's that that worries you, and keeps you awake sometimes, isn't it, it's that you think sometimes, how do I manage this now, to get the best out of it for everybody'…*Nurse 24

Balancing and weighing concerns provides evidence of negotiation by individual nurse and social work participants to secure a good outcome (however defined), was identified as part of the practitioner role. Involving a manager or safeguarding colleague emerged as part of this process. These comments are interesting and relevant because they evidence that participants felt able to change their practice or to re-negotiate or re-define

the risks that they identified. Nurse 24's comments suggest that even in situations where opportunities for support are identified (management guidance, supervision, peer support, safeguarding specialist staff) individual practitioners exercise their own decision whether to raise an adult protection concern or not. The view of Nurse 24 may not be typical of practitioners but it does highlight the individual discretion that practitioners can exercise (or not) in negotiating risks and reaching a decision whether to raise an adult protection alert. Conversely, willingness to change further to conversation with a manager or safeguarding colleague indicates that practitioners may not feel competent or confident in their decision making and anticipate that their practice will be guided when specialist safeguarding advice is sought.

The emerging themes in the four categories and core category have been recognised and discussed in this chapter. Relational maps have assisted to demonstrate and illustrate the key ideas emerging from participant interviews with nurses and social workers. The categories indicate a number of conflicts, dilemmas and priorities that influence the decision that they make in responding to allegations of adult abuse. The maps and discussions that follow in Chapter 5 explore these further.

Chapter 5. Applying situational mapping

The initial findings presented in the previous chapter using interview data indicated some strong emerging themes. Within and across the four categories and core category, a number of ideas appeared particularly significant. Using the situational analysis mapping approaches that Clarke (2005) advocates this chapter explores further some of these significant ideas. Mapping ensures that not only are key themes acknowledged but that these are critically reviewed from several different angles. Mapping is a prompt to challenge the positions originally presented in the data – increasing the analysis of the emerging data. For this reason, some participant quotations that have featured in and contributed to the initial findings chapter also appear in positional mapping in this chapter. This is not for duplication, but to contribute to another, deeper layer of analysis. Inclusion of these quotations in this chapter is to illustrate the positions taken by nurse and social work participants rather than emerging themes. The use of positional maps helps both to situate the dilemmas participants experience and to facilitate the development of theory acknowledging these complexities, dilemmas and conflicts.

5.1 Understanding the emerging theoretical storyline

This chapter outlines the development of theoretical ideas emerging from participant data. It acknowledges that grounded theory requires exploration, challenge and reflexivity applied to it to understand and be theoretically sensitive to it. The mapping methods that Clarke (2005) recommends are tools for adding another layer of analysis to the initial findings. The use of positional maps is methodical and an effective method approach for viewing, re-viewing and developing emerging and conflicting perspectives arising from the data. In my study the positional maps are used for this purpose, they represent the views articulated by participants on a number of key elements. Recognising that completing positional maps for just a selected number of key elements may appear to be in

conflict with Clarke's inclusive, democratising approach to situational mapping, it may be helpful to acknowledge the rationale for this.

Clarke (2005) explains that positional maps:

> '…lay out the major positions taken in the data on major discursive issues therein – topics of focus, concern, and often but not always contestation' (p126)

Positional maps are a mechanism consistent with Clarke's (2005) cartographic approach to analysis by which emerging categories and theory can be challenged and conflicts acknowledged. Whilst Clarke's (2005) Situational Analysis offers a set of tools for exploring agreements and conflicts within data; she is also cautious that what is unsaid by participants can be equally or more valuable than views participants articulate. Returning both to the participant data, and to the existing, albeit limited, literature creates an opportunity to recognise the meaning associated to the words (symbols) used by nurses and social workers. In addition, Clarke's (2005) analysis by use of mapping promotes identification of unacknowledged elements. Known as sites of silence these are also explored in this chapter using available data, publications and research reports to reference and understand the significance of the site of silence. Combining mapping and the acknowledgement of sites of silence prompts further analysis to understand and challenge the emerging theoretical storyline.

5.2 Emerging key findings

In my study, selective codes arising from participant interviews which persisted contributed to the development of the four categories;

- the official line,
- expectation and perception,
- non- vulnerable adult process options
- confidence and competence and the core category;
- the tipping point (explored later in this chapter)

Within each of these categories there has already been recognition of some of the key themes and contributions raised by participants in the previous chapter. This chapter explores a number of emerging key themes further.

Three themes, in particular, were identified as especially prominent in the initial findings and featured characteristics that were not unique to one core category. Table 5.1 illustrates the characteristics of emerging themes that feature in more than one category and why they are of interest as emerging key findings. These cross-cutting themes are explored in this section.

Emerging key themes	Areas of interest	Relevant Categories
Influence of relationship :	Nurse/social worker and service user family upon likelihood of raising an adult protection alert.	• Non vulnerable adult process • Confidence and competence • The tipping point
Management	• Manager or practitioner directs the decision to raise an adult protection alert. • Discussing concerns with managers – health or social care.	• The official line • Expectations and perceptions • Non vulnerable adult process • Confidence and competence • The tipping point
Decision-making and mental capacity	• Person/ practitioner leading decisionmaking. • Moving decisions to others. • (Not) My decision	• The official line • Expectations and perceptions • Non vulnerable adult process • Confidence and competence • The tipping point

Table 5.1 Characteristics of emerging themes that feature in more than core category.

5.3. Influence of relationship: adult protection decision-making.

Relationships featured frequently in a number of interviews and were identified as significant at the final point at which a nurse or social work

practitioner makes a decision whether to raise a formal adult protection alert or not. Key relationships were identified as between nurses/social workers and the family of an adult with a learning disability.

There has been emerging emphasis in policy and legislation in Wales to recognise the contribution of carers to the adults that they support. Wales had already adapted and revised policy and legislation that applied to England and Wales when it introduced the *Carer's Measure* in 2010 (Wales, 2010). The policy direction for Wales continues with proposals in the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) and plans to accord service users and carers the same status as each other. The development in Wales is proposed within a context of evidence that suggests that the carerservice user relationship is an under-researched and not fully understood issue which has the potential to sit uncomfortably with the developing person- centred agenda (Larkin, 2015). Glendinning (2015) describes the current role that family carers play in adult social care as ambiguous; both as individuals with their own (largely undefined) rights and the predominant view that family carers (in England) are a resource or co-worker rather than a co-client. James (2011, 2013) advocates that the relationship between staff and carers should, rightly, be developed to allow genuine collaboration, partnership and open, honest dialogue that supports adults with a learning disability to live the life that they want. This includes living a life free of abuse.

Supporting an adult with learning disabilities and supporting a family member/carer does not mean that the perspectives will necessarily be the same. Indeed, nurses and social workers in my research described that there were times when a family member/carer and the vulnerable adult were in, or were potentially in, conflict with each other. Whilst partnership and collaboration with family member/carers is desirable to assist adults with a learning disability to live the life they want, it does not guarantee that the expectations of the family member/carer match those of the adult themselves. It cannot be assumed that the expectations and aspirations of

family members, however well intentioned, are always wholly positive for the adult with a learning disability. Literature already recognises (Bibby, 2013) that some adults with a learning disability- at their parent/carers' wish- did not have the opportunity to live as independently as they may be capable of despite having the mental capacity to make (and carry out) this decision. As maintaining a good relationship with family members/carers was identified, by participants, as core to their practice in CLDTs there is an increased need that nurses and social workers must be skilled and prepared to ask difficult questions about abuse.

Nurse and social work participants described that having difficult conversations and asking difficult questions was frequently avoided. With little direct literature available in relation to learning disability practice, this characteristic is also noted in palliative care nursing practice where difficult questions might also be expected to part of day to day work. In one study nursing care and asking difficult questions were seen to be at odds with the positive, inclusive values associated with 21st century nursing (Marie Curie, 2014). If the views of families of adults with learning disabilities were largely unchallenged by participants where they concerned day to day living arrangements and accommodation (Bibby, 2013) – it is likely that practitioners may find asking questions about potential abuse even more difficult.

Biggs and Haapala (2013) identify that it is difficult to understand the relationships that are formed between family carers and staff without them being considered in their broader social policy context. In Wales, the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) anticipates that service users and carers will have the same legal status as each other from 2016. It is possible that it will make the separation between service users and carers less clear raising the potential for a further blurring of the lines between professional, the vulnerable adult and their family member/carer. Consequently, the need to ask difficult questions may need to increase.

The history and influence of third sector and charity organisations is predominantly that of being representative groups for parent-carers rather than representative of adults with a learning disability themselves. There remains a potential that the legacy of this is that family member/carers are viewed as 'heroes' (Walmsley, 2010) when compared to the adult with a disability that they support. The willingness of participants to negotiate potential abuse, weighing it against preserving the relationship with a service user's family, echoes the concerns that Yaffe (2009) raised. Yaffe, (2009) identified that there could be circumstances in which a practitioner finds abuse to be culturally acceptable and attributes any dissonance between the practitioner and family member/carer holding different sets of cultural values.

Commitment to family members, their views and the preservation of a relationship with them rather than the adult with a learning disability themselves required further exploration. Of particular relevance for my study is whether the relationship with the family of an adult with a learning disability influenced nurse and social worker decision-making; regardless of whether nurse and social work participants were aware of their position. The use of a positional map (Clarke, 2005) enables exploration of relationships, not only does it offer clarity of the positions taken by participants; it also demonstrates the volume and balance of ideas expressed. Figure 5.1 maps how the relationship with the family member/carer influences the likelihood of an adult abuse alert being raised.

5.3.1. Positional map: relationships with family/carer and likelihood of raising an adult protect alert

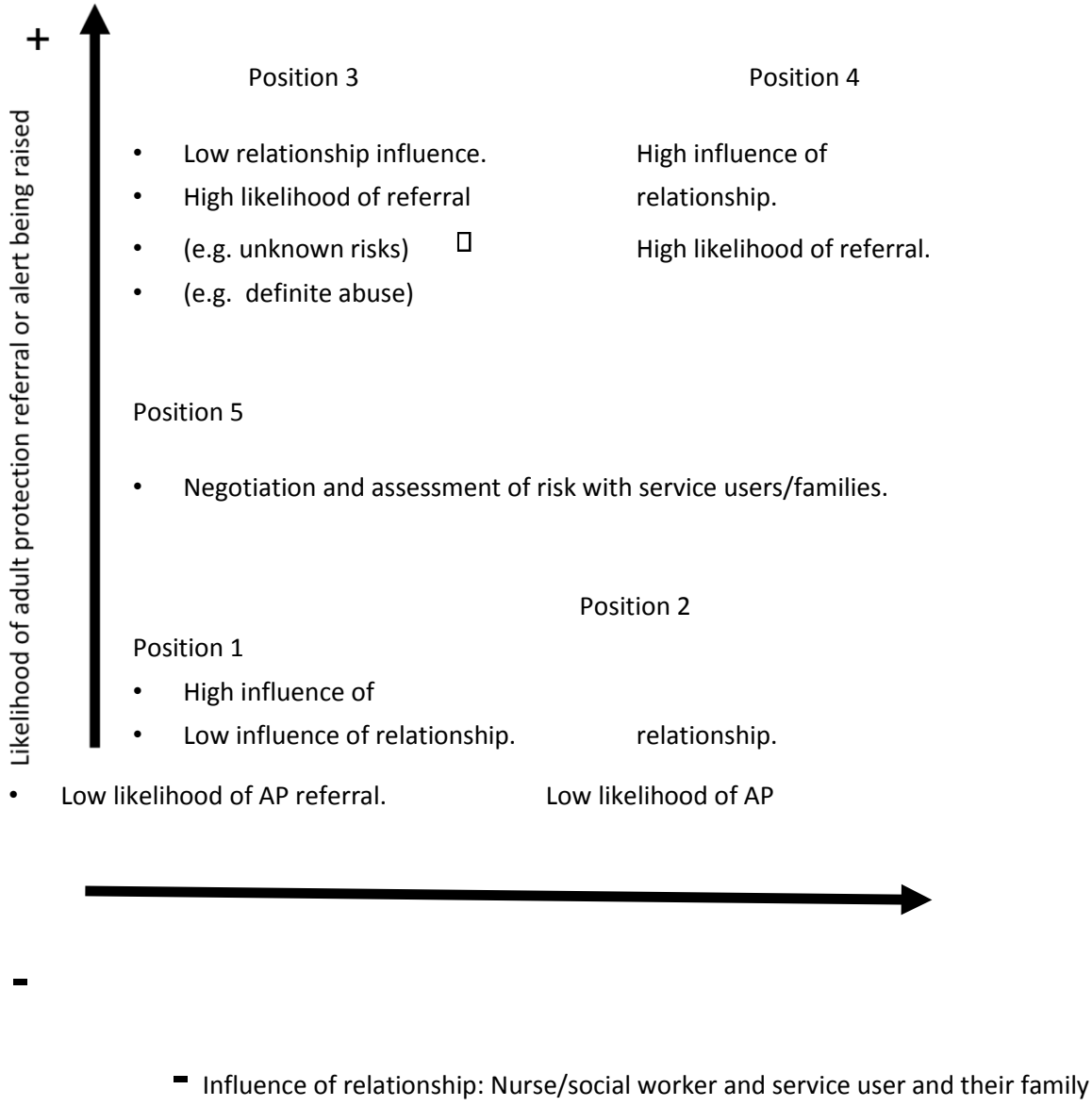


Figure 5.1. Positions of dilemma: relationships

Table 5.2 (below)comprises the comments made by participants, in positions 4 and 5 – high influence of relationship/high likelihood of referral and the negotiation/ assessment of risk respectively.

Influence of relationships :Position 4 comment- High influence of relationship/High likelihood of referral
'…people they think we don't need to maintain a good relationship but they must and that is usually their excuse. That would be their excuse not just with POVA but with any difficult conversation'. **SW 3**
'...(I) think this is why this was very emotional for me working with that case that I could see how distraught the mother was, it was awful, and worked with her for 20 odd years and tried to prepare her for this inevitable crisis and when she was going to be no longer able to care for her daughter but she wouldn't plan at all'. **N13**
Position 5 : Negotiation and assessment of risk
'I think again you have to have openness and transparency you know, I've been involved in a process, an incident in the past where what I say is, I will not apologise for this process it's here to protect people so you kind of use that language, you know, you have to be very clear'. **N25**
'It's complicated though, cause you've got to have a kind of working relationship with people, you know, and there's got to be an element of trust, you've got to develop a rapport to an extent, but obviously you have to stand back on occasions and think, am I compromising my practice here, am I not advocating on a person's best behalf, because you can get drawn in with families'. **N 24**
'So we know the families, we know, we know the service users. We know their problems, we know the issues and it doesn't, it doesn't make you complacent'. **SW 19**
*'You know, you can get, you can be friendly towards people, but I don't make that kind of relationships with people in this business, you can't. You can't.'***SW12**

'I'm not friends with anybody not my clients, not my, not nobody, you know. You go with it…'cause you go… you can always upset somebody,

and that's awful, it's awful doing it, it's absolutely terrible and it makes the job harder, and you can't sleep and it's awful, but you have to do, and you, and you have to be able to do it, furthermore, but it, you know, so no, I'd be fine with that. I'd be fine with that, if that's what's needed'. **SW 12**

Table 5.2. Positional map comments: Relationships. Positions 4 and 5.

5.3.2 Relationships: negotiation - practitioner and family of an adult

Position 5 in each positional map is a middle position; here it is a site of balance between recognising the influence of relationships with the family of service users and professional responsibilities which include identifying potential abuse. There is a significant presence of views and comments in this position that reviews a negotiation and assessment of risk – it is the risk that is negotiated by nurses and social workers rather than negotiations to support the relationship with family member/carers. Participant views in position 5 recognise that, on occasion, practice with adults with a learning disability will require asking difficult questions and explaining action required, whilst securing an opportunity to return to work with the same adult and their family in the future. The participants who articulated this position did not do so without recognising that negotiation of risk takes place in a broader practice context or the practice and personal conflicts posed by this. Maintaining this position, as Nurse 24 in table 5.2) identifies requires constant critical reflection upon practice and a need to balance professional expectations with personal and personality characteristics.

Whilst Hermsen et al. (2014) are concerned that care staff are increasingly driven by procedural bureaucracy such as the completion of forms, or meetings at pre-determined time points, they recommend that staff should deliver 'professional loving care' (p222). This phrase, Hermsen et al. (2014) suggest recognises that practitioners can be effective, accountable and

friendly without compromising their practice and professional standards. Position 5 can be summarised as situating practice that is professional, friend*ly* but in no way a friendship where the preservation of a relationship with the family member/carer is preferable but not essential when safeguarding decisions are required.

Position 4 recognises the influence of relationship upon decision-making and that an adult abuse alert is more likely. This was anticipated to be an outlying position although through the interviews it attracted two distinct participant perspectives. The first perspective was articulated only by social workers was that where raising an alert was absolutely necessary (usually where there were irreconcilable differences between the views of family and social worker) doing so was part of the professional responsibility in maintaining an honest relationship with families. This view was usually closely bound to an association to the Code of Practice (Care Council of Wales, 2015) requirements to minimise harm. The second perspective (articulated by nurses), is a sense that an inevitable crisis will occur, which, despite long term involvement with the CLDT is likely to have serious consequences for the adult that could constitute abuse. This position captured a sense of 'waiting for the right moment' to intervene, if of course it was ever considered by the practitioner to arrive. Position 4, perhaps more than any other position is a reminder that whilst a relationship may have a high influence, it may not be perceived by the participant as a positive relationship. If this response or position is applied to a relationship between staff and family which had not been straightforward-for example where complaints have been made or legal action at odds with the views of a family member/carer has been required. In these circumstances participants were aware that safeguarding intervention has the potential to be perceived by family members (accurately or inaccurately) as a sanction. Biggs and Haapala (2013) recommend that any discussion about the relationship between professional staff in health and social care should acknowledge the balance of power that can exist. This includes recognising

the balance of power between professionals and family members and how taking necessary safeguarding action may affect this.

Where nurses and social workers identify with position 4 they are acknowledging the potential that there is a higher likelihood of raising an adult protection alert and that the relationship with the family member/carer may have a greater than usual/anticipated influence upon this.

5.3.3 Relationships with family member/carer: High influence and likelihood of action

Table 5.3 (below) illustrates only position 2 the position of a high influence of the relationship with low likelihood of referral. That the position has attracted a large number of comments from social workers and nurses requires some discussion. Clarke (2005) warns new researchers that there will be some positions that are entirely unoccupied and that some anomalous or outlying position may also emerge. What Clarke (2005) does not warn of, and for which I was unprepared, is an overwhelming presence of data in one position. Table 5.3 comprises the comments from position 2 (high influence of relationship, low likelihood of adult protection alert being raised).

Influence of relationships: Position 2 High influence of the relationship with low likelihood of adult protection referral/abuse alert being raised
'*Yes, absolutely and I knew you know, that, having known the family for many years, that the family would be devastated which they were but then it's about working with the family then as well isn't it you know, and trying to pick up the pieces there'.* **SW 14**

'The possibility is that we could be put at risk ourselves by doing that um we could ruin the relationships that we have with service users and their carers. I really don't know, I think my gut reaction is that it's probably not a great idea'. **SW 8**(discussing possibility of care and support orders).

'*cos it's a bigger, yeah, yeah, 'cos there's not someone there every day, so you need quite a close relationship with that person for them to tell you what's going on, and to feedback'.* **SW 12**
Q: ... (does the relationship) influence that decision-making as well because you were saying some services have known families for thirty years or so? *'Yeah, it could be especially where there's a well-known,*
well-liked family it could be that you think 'oh they'd never do anything like that' because you've got this really good relationship with them'. **SW 20**
'Also as well the problem we've got in adult protection in relation to learning disabilities, families throw a protective cloak around the service users so on times it's very difficult because people, they show you the door, say thank you but no thank you. So on times it's difficult to address some potential issues especially around financial abuse. It's very much of a land-mine especially for a social worker within learning disabilities'. **SW 21**
'because, er, some members of the team have worked, er, with particular individuals for many years, um, I tend to rely quite heavily on their past experience'. **SW 22**
[There is a]*'cosiness of relationships between professionals and with the family it's a very small close knit community'.* **SW 3**
'So it's a little bit difficult um to address issues, where you're seeing somebody you've known her for ten years and you can say to them, look I'm flagging this up, we're unhappy with this'. **SW 21**

'That's it, I think sometimes people press the big red button before they really need to, and I think there's, that can do a more damage than good to relationships when you're managing them'. **SW 12**
'You know sometimes you can think ah I know that person, they're always like that and possibly its familiarity'. **SW 11.**
'I suppose so, that example I gave you I have a good relationship with the family but I have to put the safety of the child first. And it was very difficult with the family, they were really disappointed with me'. **N5**
..'she always used to call me like oh you are like a daughter to me because that is the great thing and the unique thing about working in the
*disability service, particularly a nurse, you are able to work with your families for most of the time for long term you know you are in it for the long haul and you do build up relationships'.***N13**
Q: I was going to ask about that, whether the relationship and the knowledge of service users and their families sort of had the potential to influence some of the decision-making. **Participant :**'*I would be a liar to say it didn't'* **SW 16**
..'and you know prior knowledge with the history of the person or the personality of the person, sometimes the more you know about them kind of sways the way you react to the VA1 so we try and steer away from that if we can' **SW 16**
Q : And if it is a situation you know quite well and you know people in can that be difficult? **Participant :**'*It can be, it can destroy relationships. Working in this field is not like general medicine where you see someone once in their lifetime, we frequently have to go back into that place and it can make people weary of disclosing things to you, but at the end of the day we are there to safeguard that person'.***N4**.

Table 5.3 Positional map comments: Relationships: Position 2.

The frequent description of relationships by participants as familial and enduring accompanied by references to the likeability of families was striking. The findings illustrate that, consciously or not, the family member/carer is perceived to be the advocate and proxy decision maker for the adult with a learning disability. There was a clear commitment to protect relationships with families wherever possible. The benefits of doing so were identified by participants as maintaining access to the adult with a learning disability and that conflict with family was avoided. Participant nurses and social workers who adopted this position were potentially declining to explore indicators of abuse to avoid conflict with family members. Where participants considered that raising potential abuse was likely to restrict future access to the adult it was surprising that this was not itself recognised as a potential indicator of abuse. In discussing opportunities for the voice and experience of adults with a learning disability to be heard McVilly et al. (2006) articulated that fewer relationships are likely outside of the family and staff members that support them. This promotes rather than reduces the need to be critically aware of the influence of relationships with and between professionals and service user family members.

Bowler and Nash (2014) are concerned that learning disability nursing staff should be alert to the privilege of their position and mindful to maintain professional boundaries. Viewed in the context where professional boundaries are expected to be clear, the sentiments expressed by participants who indicate that raising concerns is tantamount to disloyalty to families are especially interesting. The close nature of relationships between staff and family carers allied with the trust placed in them by family members- considered so important by participants in the previous chapter- combine to form a high influence of relationship and low likelihood of raising adult protection concerns. To preserve the relationship with family members/carers participant nurses and social workers may consider that an adult protection alert is required but perceive it as a failure or shortcoming in their own professional practice. This view may be especially

relevant where a professional had known a family for many years, and could weigh the new and arising risk information with historical knowledge– thereby reducing the likelihood of adult protection referral.

5.3.4 Summary: relationships

Emerging as significant to practitioners, the positional map has assisted further analysis of the impact of relationships with the families of an adult with a learning disability upon whether nurses and social workers raised an adult protection alert. Three key positions were explored; assessment and negotiation of risk, high influence of relationship/ high likelihood of raising an adult protection alert and lastly; high influence of relationship/ low likelihood of raising an adult abuse alert. There are two positions that have no commentary in this section; position one – low influence of relationship/ low likelihood of raising an adult protection alert and position 3 – low influence of relationship/high likelihood of raising an adult protection alert attracted no comments. This may be attributable to nurses and social workers in the CLDT expressing that relationships are central to effective practice, and that even where the influence of the relationship had negative associations for the participants–the influence was recognised. An alternative view is that as it predominant practice for adults with a learning disability to be allocated to a worker – even if this results in excessive and unrealistic caseloads (Slevin et al. 2008) there are likely to be fewer interventions that require a member of staff to make an adult protection decision where there is no relationship with or a low influence of relationship with a family member/carer.

Identified as key influences upon their adult protection practice, by nurses and social workers, managers featured both as central to operational practice in relation to decision-making and as a central relationship within the CLDT. Within the CLDT there are NHS and Local Authority Team Managers, with the differences emerging as significant.

5.4 Management

The influence of managers upon the decision-making of individual nurses and social workers has already been identified as significant. The influence of managers emerged as significant both to individual practitioners in the form of guidance and (in the case of social services managers) as custodians of an organisational interpretation of a threshold at which an adult abuse concern should be raised. To explain the influence and impact of management upon the decisions that social workers and nurses make two positional maps were created. These acknowledged and explored two diverse findings emerging from participant interviews:

- Discussing concerns about abuse with managers: NHS or Local Authority?
- Who directs the decision to raise an adult protection alert – manager or practitioner?

The two ideas are significant for this research project because they connect to key findings of this study and to existing adult protection guidance. It is not the decision-making of managers that features as significant here – only if, how and to what extent managers influence the decisions that social workers and nurses make. The next section explores and analyses the identification of managers to whom participants direct their safeguarding queries using positional mapping sources of management support with the NHS and Local
Authority.

5.4.1 Management support: NHS or Social Services?

The positional map in figure 5.2 acknowledges that whilst nurses and social workers sought guidance from managers employed by both health and social care, references to ‘managers’ were most frequently those within social services–usually a CLDT Team Manager. The positional map in figure 5.2 and accompanying table 5.4 explores the positions taken by participants that demonstrate whether they are most likely to discuss initial concerns with an NHS or Local Authority manager.

5.4.2 Positional map: raising initial concerns with NHS/ Local Authority management

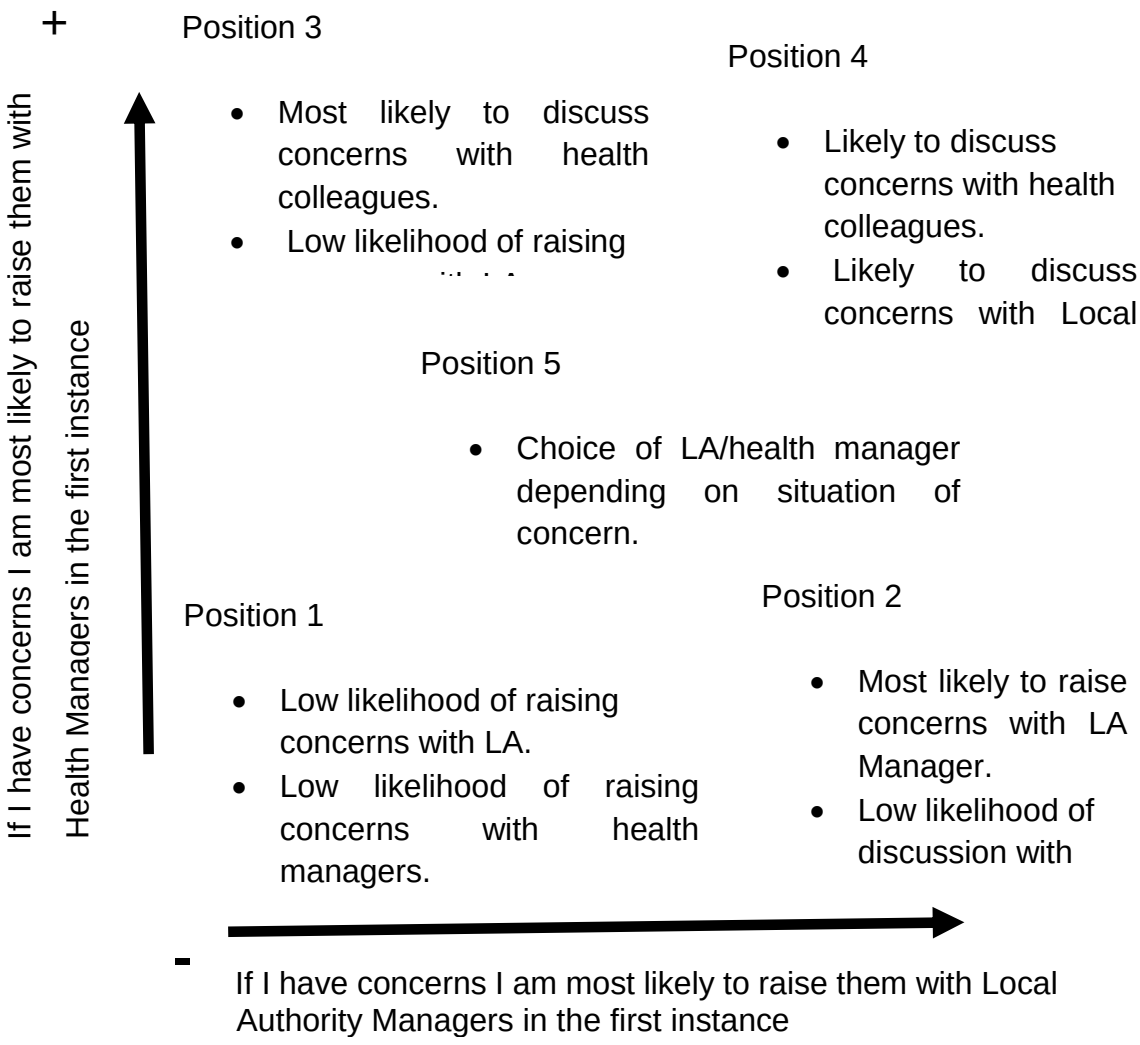


Figure 5.2. Positional map: Raising initial concerns NHS/Local Authority Managers.

Acknowledging that adult protection guidance applies to nursing and social work the comments in all relevant positions are only drawn from interviews with nurses. This is due to only nurses identifying management support outside of their own organisation as a route of contact and support; no social workers identified that they had initial discussions about an adult abuse concern with an NHS manager. This is, perhaps, unsurprising given that the previous chapters have recognised that in the community, the Local Authority has the lead responsibility for adult safeguarding. Speaking to Local Authority managers may be perceived by participants as liaising with and taking corporate or organisational guidance from the lead organisation for safeguarding. Whilst sources of management support may change over time when working with an adult with a learning disability, this section is focussed only upon the manager with whom practitioners have initial safeguarding conversations.

Table 5.4 contains the participant comments associated to the positions taken in figure 5.2, a positional map that shows where nurses – regardless of the configuration of their team as integrated or co- located - seek management support.

Position 2 : Most likely to raise concerns with LA Manager/ Low likelihood of discussion with health manager
'*So I found that, I found myself quite cut adrift when I was in a health situation and they couldn't make that decision whether it was an incident or a safeguarding issue, a clinical incident'***N25**
'*My experience of the safeguarding POVA process, because I've been a community nurse for so long has always been within community services and I've never until recently experienced health taking the lead…'***N25**

'*Yes so I think even if my manager was unsure he would go to Social Services manager'* **N5**
*'it's my understanding that social services usually take the lead on these things..'***N2** *'The VA1's go to the social service manager'***N2**
Position 5 :Choice of LA/health manager depending on situation of concern
*'Discuss it with a manager or a social work colleague or whatever'***N4**
Position 3: Most likely to discuss concerns with health colleagues/ Low likelihood of raising concerns with LA manager
*'...spoken to our POVA lady up at (Health property)'.***N4**
[I] *'immediately report it to my senior nurse'*. **N13**

Table 5.4. Initial discussions with health or social services managers.

Manthorpe et al. (2010) suggest that in relation to adult protection practice within a multi or interdisciplinary setting Social Services managers may have a unique (and possibly partisan or personal) perspective. The same perspective is not necessarily adopted by all Social Services managers within a Local Authority, or in all Local Authority areas, as each manager is part of their own broader organisational and inter - organisational context. The identification of social work/social services managers as central to the development of adult protection process and practice is not new. Manthorpe (2010) confirms the identified significance of Local Authority managers to safeguarding practice in both England (McCreadie et al., 2008) and Wales (Northway et al. 2007). Referring to nursing, Hofmeyer (2013) adds that the relationship between managers and staff and achieving good outcomes for patients is well established. This is a problematic view for this study; not because the value of the relationship between managers

and staff is doubted, but because the management that is identified by nurses in my study is not their own manager (to whom Hofmeyer (2013) referred) but predominately to those within the Local Authority.

5.4.3 Management: Local Authority managers as CLDT safeguarding contact

The highest volume of participant comment was in position 2 – the position in which nurses were most likely to raise concerns to a Local Authority manager and a low likelihood of raising concerns with a health manager. In this position two key distinct views emerged. Firstly, as the lead organisation for adult safeguarding, a manager from within the Local Authority was presented by participants as in a stronger or more authoritative position to offer advice and guidance. The second view that emerged was that a Local Authority manager was more likely to offer clear guidance and to have more experience of responding to abuse than NHS managers. Nurse 5's comment reinforces this view–not only do individual nurses within the CLDT look to the Local Authority manager for guidance but that NHS Team Managers also looked to Social Services colleagues for guidance in responding to allegations of potential abuse.

5.4.4 Management: Health managers less likely to be CLDT Safeguarding contact

Position 3 (most likely to discuss concerns with health colleagues/ Low likelihood of raising concerns with LA manager) and 5 (choice of LA/health manager depending on situation of concern) are both occupied by comments from one nurse– Nurse 4- which has the potential to present a misleading or conflicting view of seeking support. Nurse 4 described in the research interview that they seek support at the time that they need it – and that this support may be gained from an NHS manager (a health specialist safeguarding manager was referred to) or from a Social Services colleague or manager. Galvin and Timmins (2010) identified three management characteristics most valued by learning disability nurses in a study in

Ireland; approachability, availability and flexibility (Galvin and Timmins, 2010). The availability of support and the opportunity to talk concerns through at the time of concerns arising was more significant than who the conversation was with–the view expressed by Nurse 4.

The action that follows an initial conversation between and manager and a nurse or social worker is now discussed.

5.4.5 Management: Manager or practitioner directs the decision to raise an adult protection alert?

Managers are identified by participants as involved with supporting nurses and social workers to discuss concerns about situations where they identify potential abuse. It is now necessary to explore to what extent managers influence or direct the action that nurse and social workers take following these initial discussions. Figure 5.3 is the positional map that illustrates this, whilst table 5.5 presents the accompanying participant comments.

5.4.6. Positional map: Manager or practitioner directs the decision to raise an adult protection alert?

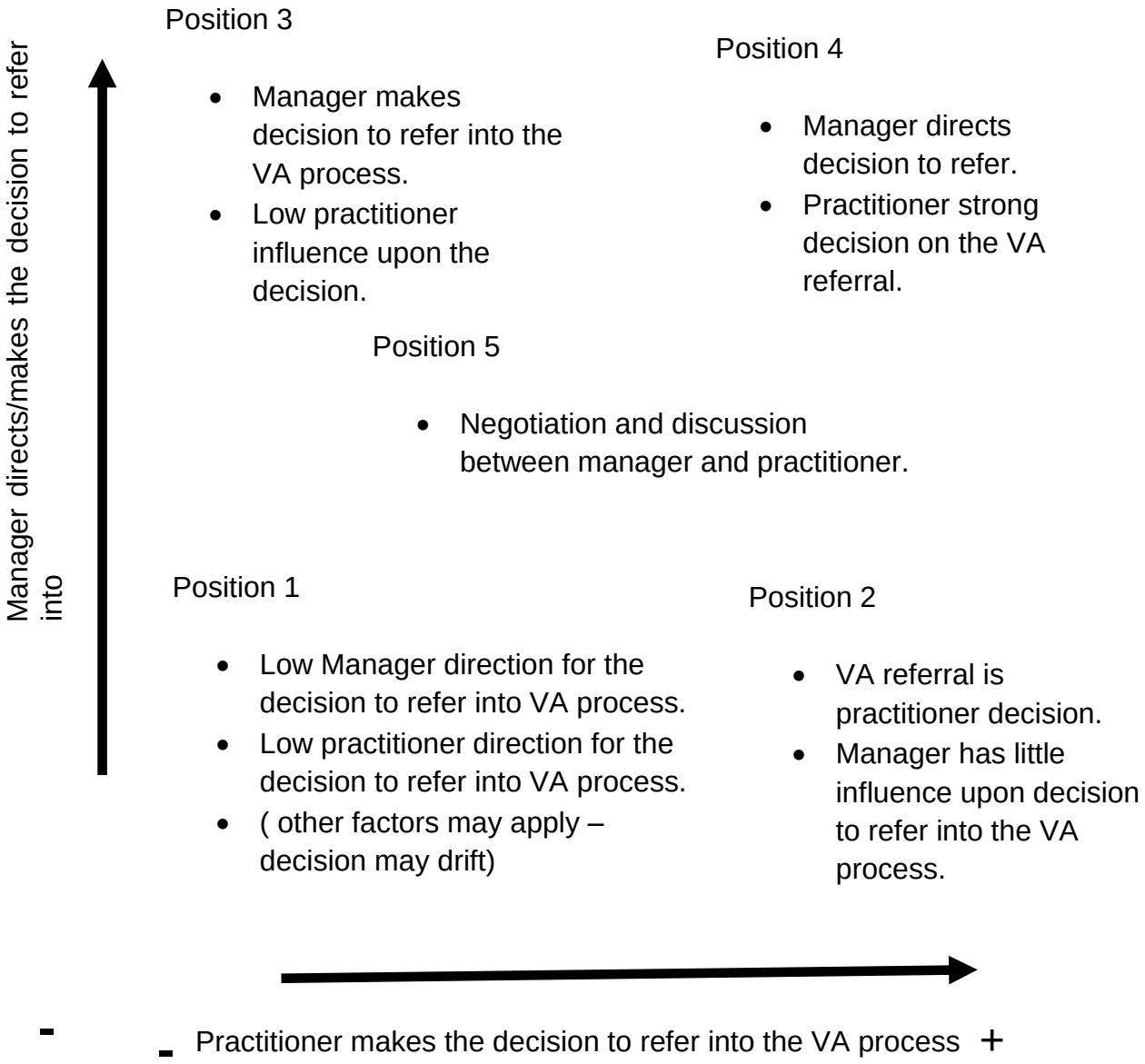


Figure 5.3: Manager/practitioner decision-making regarding vulnerable adult process.

Table 5.5 demonstrates participant responses position 3 and 2. The positional map indicates a strong presence or volume of responses in position 3 – the position in which a manager usually directs/makes the decision whether to recognise an incident as abuse and raise an alert. It is realistic that conversations took place between the participant and their manager but that the final site of the decision was not that of negotiation.

Participants tended towards describing both respect for the knowledge of individual managers and for the position that they occupy within the organisation-leading to the manager having the final decision whether an alert is raised.

Position 3. Manager makes decision to refer into the VA process/ Low practitioner influence upon the decision.
'Well, I tend to think as a Team Manager is they very much know the clients, very much know the answer of where to go to solve that problem and the resources which are available'. **SW 21**
'I think because we've worked with people over many years, I er, especially the Team Manager here has got huge experience and knows all the service users and their families, and er, so I tend to rely quite heavily on that really'. **SW 22**
'I'd discuss it with my manager absolutely definitely, somebody with a lot more experience or senior practitioner whoever'. **SW 19**
..'the management … of that organisation to make sure that staff are au fait with procedures that staff stick [to them]..'**SW 3**
Position 2 VA referral is practitioner decision/Manager has little influence upon decision to refer into the VA process
'.(if) *.somebody made a disclosure, I mean that decision then would be mine. I mean I would be the person completely the VA1'.***SW 14**
you can't go running to the manager in everything, saying, you know…**SW 3**

Table 5.5 : Management/practitioner decision-making: positions 2 and 3.

Garner and Evans (2002) recognise that practitioners can be motivated by ' getting the job done' (p165), consequently, they suggest, decisions that are made by individuals can quickly acquire the characteristics that their employing agency values most. In this way it is likely that local or organisational perspectives and priorities are developed and perpetuated within the organisation. Carr (2011) is concerned that an increased focus upon local priorities has the potential to distract practitioners and the

organisations that they work for from genuinely engaging with adults about their expectations as to how best to keep safe. The priorities that Carr (2011) identifies as contributing to an organisational perspective include monitoring and achieving performance targets, and contributing to audit – all of which are a feature of Local Authority commitments in Wales. Local Authority managers whether consciously or not, are likely to become to their team the custodian of their own and organisational perspectives as to when an adult abuse alert should be raised. This emerging theme has similarities to those identified by McDonald et al. (2008) in relation to the abuse of older people. That is that there is growing trend within social work practice to rely upon formal systems such as line management rather than individual professional knowledge and experience to legitimate their actions (McDonald et al.
2008).

The responses in position 3 of this positional map in which managers direct safeguarding decisions are all drawn from social workers. As a result, figure 5.5 demonstrates only whether social workers or their managers make a decision about further action. The positional map illustrates that whilst individual nurses and social workers approached social services managers to discuss concerns, managers were to guide and instruct them as to whether an adult abuse alert was required. This view emerged as the prevailing and predominate perception of social work and nurse participants in this study

The participant views represented in position 2 that managers have little influence upon the actions taken by participants emerged as a minority view in my study. This position is only adopted by two experienced, confident social workers, who also have other roles within the adult protection process. As a Designated Lead Manager in the adult protection process Social Worker 3 also describes during the interview that they supervise and manage other staff and that they are a practitioner-manager who is asked for advice by less experienced or less confident staff within the CLDT.

Instead of undermining the strength of the emerging theme that managers have a high influence upon the safeguarding action that is taken this is congruent with it. Only participants who have experience of safeguarding practice beyond the CLDT and/or management responsibilities identified that they would independently direct a safeguarding decision. The participants in this study are all registered nurse and social work practitioners within a CLDT. No other exclusions were applied in recruitment with participants employed as case managers, senior practitioners or supervisors and Team Managers. This is significant as Thacker (2011) identified that more senior the person making a decision the more tolerant of risk they were likely to be.

It was anticipated that position 1 and position 4 would be outlying positions on this map. Position 1 refers to decisions that are without direction of practitioner or manager, which would indicate that whilst abuse is recognised a decision is consciously left to drift. Whilst decisions may be avoided and delayed or indicators of abuse may not be recognised there are no participant comments that support this position. For similar reasons position 4 is an outlying position–it is impractical that both manager and practitioner can both direct a decision about abuse; they would be in a position of potential conflict as either one person has to direct the decision or negotiation is required.

5.4.5. Summary: management

The two positional maps (figures 5.3 and 5.4) acknowledge the identification of Social Services managers as leaders on safeguarding matters who exercise their influence to direct adult protection action. Achieving a consistent approach across Wales as the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) anticipates is likely to require a reconciliation of individual, team, management and organisational perspectives. Indeed, the Care Council for wales (2015a) reiterates that multi-agency working - a key principle of the Social Services and Wellbeing

(Wales) Act 2014 (Wales, 2014) - will promote cooperation between Local Authorities and in turn create and strengthen opportunities to ensure greater voice and control for people in Wales.

The links with the four categories and core category continue to be clarified by use of positional mapping; further identifying that adult protection decision-making moves around and between colleagues within and outside the CLDT. The movement of this decision has the potential to delay effective decision-making that prevents or reduces further abuse.

The influence of managers upon the action that social workers and nurses take has emerged as significant, either by recommending, rejecting or delaying what action is taken when abuse is indicated. What now requires consideration is the extent to which the ability of an adult with a learning disability to make decisions about their own life influences the safeguarding intervention of a nurse or social worker working with them.

5.5 Mental Capacity: balancing promoting independent decisions with adult safeguarding action

The Mental Capacity Act 2005 (Great Britain, 2005), which applies to England and Wales became the first piece of legislation under which explicit prosecutions for adult abuse were possible. The legislation, however, only applies to adults without the ability to make their own decisions – a concept known as mental capacity. The Mental Capacity Act 2005 (Great Britain, 2005) clarified that adults should be presumed to have mental capacity to make decisions about their own lives unless assessed not to have mental capacity.

This is significant because it formalised that adults who can make a decision on a specific matter should have the opportunity to do–regardless of whether it might appear to a family member or professional to be an unwise decision. Conversely where an adult is not able to make an informed decision about a

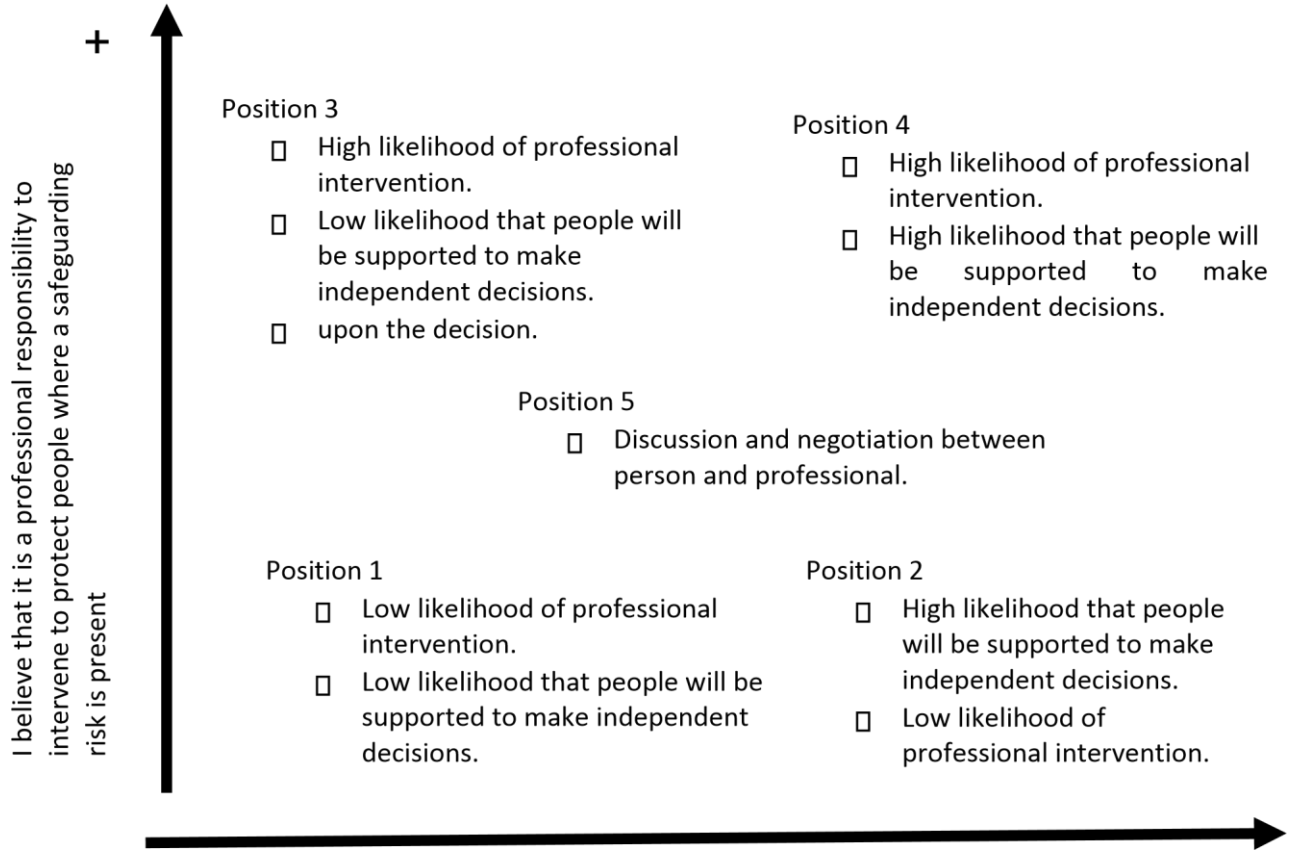
situation or circumstance a professional may be expected to make decisions and to intervene in the 'Best Interests' of the person. The Mental Capacity Act 2005 requires that adults are supported to make decisions about their lives whenever possible; where it is not possible the Mental Capacity Act 2005 (Great Britain, 2005) provides a process (Best Interest decision-making) by which the decision can be taken by another person, including nurses and social workers. Failure to intervene appropriately to support mentally incapacitated adults - for example to prevent the abuse of an adult-exposes professionals to the risk of prosecution for the crime of wilful neglect under the Mental Capacity Act (Great Britain, 2005).

Participants in my study recognised, appreciated, and were challenged by the application of the Mental Capacity Act 2005 (Great Britain, 2005) to the experience of individuals, noting the need to balance risk and choice. The challenge was expressed both as a moral and a practice challenge. Sexton (2009), identifies that adult protection decisions are complex and challenging, with agencies, (including the NHS and Social Services) having their own priorities and drivers, and own view of what constitutes 'promoting independence' and 'protecting from harm' (p84). Leyshon and Clark (2005) suggest that nurses working with adults with a learning disability will be familiar with the dilemmas of consent to nursing treatment, but that the Mental Capacity Act (2005) (Great Britain, 2005) extends the need for nurses to understand and be able to apply the principles of the Mental Capacity Act (2005) to wider practice.

Recognising that proxy decision-making and supporting an adult to understand and make decisions about their own risk can potentially be in opposition, they contribute to the axes for the final positional map (figure 5.4). The left hand axis responds to the challenge that participants expressed as wanting to intervene to reduce the possibility of abuse, whilst the lower axis concentrates upon promoting independence – including the possibility that this will include making unwise decisions. Table 5.6 (below) presents the participant comments associated with this positional map.

5.5.1 Positional map: mental capacity: balancing promoting

independent decisions with adult safeguarding action



- - I always support a person who has the mental capacity to do so to make decisions about their safeguarding risk – including unwise decisions. +

Figure 5.4. Mental Capacity: Intervention and promoting independent decisions.

Position 4: High likelihood of professional intervention/ High likelihood that people will be supported to make independent decisions
'People have; you know they are able to make unwise decisions if they have capacity. You know, they are the ones that worry me, you know, and the tipping point is when they're really exposing themselves to harm'. **N25**
Position 5 Discussion and negotiation between person and professional
'*I would say of my service users, (they) wouldn't have capacity so the (mental capacity) process is very supportive around that'*. **13**N
…'and of course, when somebody doesn't have capacity, or has impaired capacity, then you have to support them and minimise risks where you can, but not to the level where they can't enjoy their life or have freedom to even make mistakes, you know, you've got to have that'. **SW** 12
Position 1 Low likelihood of professional intervention/ Low likelihood that people will be supported to make independent decisions
...'feels a little bit uncomfortable because she has got the sort of capacity apparently'. **SW** 11
Position 2 High likelihood that people will be supported to make independent decisions/Low likelihood of professional intervention
...'and she's got capacity, she knows what she's doing but she's very limited as well and her understanding is not very good so advice from the safeguarding wasn't, we couldn't go down the sort of safeguarding route but the advice was to have a meeting and go through all the risks

and make her clear and understanding of what those risks are and the consequences could be'. **SW 20**
*'Well thinking, thinking about the capacity issues first, if somebody has got capacity to make a decision or not, how vulnerable they are and they um could put themselves in risky situations and weighing up the risk then, you know, how much do they put themselves in those situations, how much is their choice, how much is they don't understand'.***SW20**
*'I suppose our clients are adults although if they haven't got capacity it's best interest although a lot of our clients will actually want to remain home understandably 'cos that is their family at the end of the day'.***SW11**
..'cannot force your way through over the doorstep if you're concerned about somebody's welfare, unless you go down the court of protection, or if they have got capacity'. **SW7**
Position 3 : High likelihood of professional intervention/Low likelihood that people will be supported to make independent decisions
...'a decision in their best interest'. **N5**
*'I don't see what the I don't see what the difference is, whether you're protecting an child, you know, especially if that person has, lacks capacity, you know? If they lack capacity and don't have a choice, you know'.***SW12**
*…'it's issue specific well has the person got the capacity to make the decision or do we need to go down the best, you know, down a best interest route and then you know, you've got the lack of legislation as well but the big issue is capacity'.***SW14**
'If somebody comes along and says well you're impinging on that person's rights and choices, I would prefer to be criticised for being over cautious
rather a little bit blasé hiding behind the thing that people's rights and people's choices'. **SW 21**

Table 5.6 Positions taken: Mental capacity and promoting adults to make independent choices

Table 5.6 identifies the positions taken by participants and demonstrates a broader spread of participant comments than in previous maps, with at least one relevant participant comment in each position. The busiest positions are the opposing positions 2 and 3, demonstrating the tensions that practitioners experience between supporting an adult to maximise their mental capacity, independence (and possibly take increased risk) and intervening when an adult is assessed as not having mental capacity.

Few comments in relation to mental capacity in my study are made by nurse participants, with most contributions being made by social workers. The social worker comments are predominately polarised in position 2 (high likelihood of support to make independent decisions/ low likelihood of professional intervention) and position 3 (high likelihood of professional intervention and low likelihood of support for independent decision-making). Nurse participant comments were more broadly spread, featuring in position 5 (negotiation) and the more interventionist positions of 3 and 4 (high professional intervention, high support for independent decisions). The spread of the positions taken makes deeper analysis problematic and indicates that participants have both mixed perspectives and mixed understanding of how the Mental Capacity Act 2005 (Great Britain, 2005) applies to practice. Discussion of mental capacity is no less significant because no clear positions have emerged, but it is the spread of views and the confused picture that generates additional interest.

The comments of participants indicate different levels of understanding of the application of the Mental Capacity Act 2005 (Great Britain, 2005) to practice; Social Worker 11 comments of an individual that:

> *... 'she has got the sort of capacity, apparently'...*(Social Worker 11)

An adult's ability to make informed decisions may vary over time and across a range of issues on which decisions may be required, necessitating several assessments of mental capacity. The Mental Capacity Act 2005 (Great Britain, 2005) and accompanying code of practice (HMSO, 2005) are clear that a person either has or does not have mental capacity to make a decision (however borderline) based upon the evidence available at the point of time of the assessment. Whilst this may be uncomfortable for practitioners both to assess and to work with it is possible that this may have been misunderstood. This is not to suggest that mental capacity decisions are static, as Suto et al. (2005) clarify: *'decision-making capabilities are not fixed and can be improved'* (p7). Nurses and social workers are required to review decision-making each time that a decision is needed to ensure that it is current and issue specific.

Where a professional is potentially required to intervene to safeguard a vulnerable adult who does not have the mental capacity to make an informed decision the professional must satisfy *themselves* with the quality and recommendations of the mental capacity assessment and coordinate the Best Interests decisions that follow from it.

On an issue specific basis, the guidance to the Mental Capacity Act 2005 is clear that assessment of capacity is a snapshot of ability to make a decision at a particular point of time. Nurse 13 comments:

> *... 'I would say of my service users, (they) wouldn't have capacity'…(*Nurse 13)

This comment suggests that assessment of mental capacity may be incorrectly viewed as a one – off, universal assessment. Nurse 13 appears to presume that all of the adults that they are working with do not have mental capacity, rather than the required Mental Capacity Act 2005(Great Britain, 2005) presumption that they do.

Although not referring to decisions about adult abuse, Wilner et al. (2011) researched health and social care professional staff understanding of the Mental Capacity Act 2005 and application to practice. In their study in South

Wales they identified patchy, if not poor, understanding of assessment of mental capacity and when Best Interest decisions were appropriate. Brown and Marchant, (2013) reviewed cases that were considered by Local Authorities and Health Boards to be complex; all of which contained issues of mental capacity and decision-making. The study, they clarify, was prompted by *'a felt sense that practitioners were struggling to apply the clear framework set out in the (Mental Capacity) Act to real life'* (Brown and Marchant, 2013, p60)

Where understanding is patchy it is possible that the quality of practice will be affected and individual adults will be denied opportunities to make their own decisions. Whilst front line health and social care professionals were noted to have inconsistent awareness of mental capacity, Manthorpe et al (2009) found Social Services Adult Protection Coordinators to be well informed. However, before the safeguarding concerns of an individual adult are brought to the attention of an Adult Protection Coordinator, the mental capacity of the individual adult will have been assessed and reviewed at least once and by at least (and possibly more than) one professional practitioner.

5.5.2 Mental capacity: choice, risk and independence

The positional map in figure 5.6 has as on its axes two statements:

- I believe that it is a professional responsibility to intervene to protect people where a safeguarding risk is present

and

- I always support a person who has the mental capacity to do so to make decisions about their safeguarding risk – including unwise decisions.

Whilst these two position statements are a polarised simplification of the dilemmas that participants identified, they do reflect the broader challenges that nurses and social workers identified. Working with adults with a learning disability is unlikely to be an all or nothing experience and this was identified as part of the dilemma of supporting someone who is assessed as being able to make their own, albeit unwise decision. This dilemma was

summarised by the concerns of Social Worker 21 (position 3), who identified that exercising choice could expose an adult to unnecessary and extended potential risk of significant harm. Carr (2011) recognised the presence of professional dilemmas in practice and that choice and control are not mutually exclusive and neither can be the decision-making that supports this.

Researching with adults in a learning disability residential setting, Gill and Fazil (2013) also identified confusion between two conflicting values; independence and choice as determined by *Valuing People* (DH, 2001) and 'duty of care' – a commitment to acting with the best intentions towards the adult. This confusion, for Gill and Fazil (2013), was evidenced in a study where adults who were assessed as having decision-making ability were left to make unwise decisions (about their diabetic diet) but without any focussed, learning disability specific guidance, information from professionals or support. Consequently, Gill and Fazil (2013) identified that adults with mental capacity had poorer health outcomes resulting from the choices made than those without mental capacity where staff provided increased support.

Watt (2008), writing from a nursing perspective queries whether limiting information and the use of 'benevolent deception' (p42) may be appropriate in some circumstances where an adult has no or limited mental capacity to make a decision. This, he does acknowledge has the potential to undermine opportunities of choice and control for people who lack capacity and perpetuate practice that may exclude rather than include adults in activities that affect their life.

5.5.3 Mental capacity: summary

Watt (2008), advocates the use of a proportionate response (regardless of mental capacity) to a situation; tailored to the requirements of an individual; even if the lines between choice and intervention – if not control- are at risk of becoming blurred. This is likely to be a view with which several participants in my study have some sympathy.

Stalker (2003) is also unconvinced that decision-making, choice and control are, or should be mutually exclusive or polarised positions. She urges social workers to '*reclaim their position as experts in uncertainty...make fine judgements about risk and dare to work creatively an innovatively'* (p228). Despite this enthusiastic call almost a decade before the start of my study, the positional map in figure 5.6 has few comments that explicitly relate to a negotiated outcome.

The positions that are not taken in each of the positional maps may be as helpful to understanding emerging themes as those that are explicit. These 'sites of silence', Clarke (2005, p85) provide additional analysis; these are now explored in relation to the emerging themes and completed positional mapping.

5.6 Sites of silence

> 'In seeking to be ethically accountable researchers, I believe we need to attempt to articulate what we see as the *sites of silence* in our data. What seems present but unarticulated? What thousand-pound gorillas do we think are sitting around in our situations of concern that nobody has bothered to mention yet? Why not?' (Clarke, p85)

Clarke's (2005) comment outlines that sites of silence may exist for a variety of reasons. These may include that a phenomenon has not been considered relevant to debate and have been excluded by participants (consciously or unconsciously) or potentially that is it accepted as so obvious that it is not referred to. These unarticulated views are now explored with particular emphasis upon four sites of silence:

- Adult with a learning disability
- Not asking further questions where abuse may be indicated
- Preserving the relationship with the family of the vulnerable adult
- Not my decision

5.6.1 The adult with a learning disability

Sites of silence, Clarke (2005) identifies can exist for one of two reasons; either the matter is taken for granted as present and tacitly accepted or it is absent from the discourse. The presence of the adult with a learning disability has been reviewed in the emerging participant data to consider why the adult may emerge as a site of silence. The overwhelming volume and intensity in the project data of the representation of relationships between participants and the families of adults highlighted and confirmed the adult themselves as absent from the data.

This phenomenon was also identified by the Looking into Abuse Research Team (2013), who recognised that the views of people with a learning disability were infrequently sought. Where views of individuals are not sought they cannot be pursued - reinforcing the finding that the individual adult is a site of silence. Hollomotz (2011) recognised in a study in which day to day or mundane choices that where adults with a learning disability were frequently offered limited choices or options from a pre-arranged *'menu of choices'* (p234) not determined by the adult. Being safe or having opportunities to be safe is unlikely to feature on such a menu of choices, however, if it is not a permanent feature on a professional's agenda for discussion it is unclear how the conversation is initiated.

In 2012 Hollomotz described that adults with a learning disability, attending day services were able to describe incidents with which they were unhappy or uncomfortable – none of which had been considered as significant to trigger discussion for an adult protection referral. In addition, Hollomotz (2012) identified that even where adults did recognise an incident with which they were unhappy, staff (in this case day centre staff) may be reluctant to take their accounts seriously; attributing individuals with characteristics such as *'drama queen'* or *'challenging'* (p126) serving to negate or minimise their experience. The impact of abuse upon the individual – the assessment of significant harm that safeguarding guidance in Wales promotes is, in this way unlikely to be explored. All of these perceptions and missed

opportunities serve to exclude the adult from conversations about their experience of abuse and to reduce the possibility that an adult can raise and discuss the abuse that they experience. The Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) restates that an adult should be at the centre of choices about their lives and safety-a view that is conflict with the emerging evidence from this study. As a key principle of the Act (Wales, 2014), promoting an adult with a learning disability to have a genuine 'voice and control' (Care Council for Wales,2015a) of their situation is likely to require further critical consideration to ensure the aspiration becomes embedded in practice.

The focus of interviews with social workers and nurses in my study has predominately prompted mention of process, procedures and professionals, with little mention of the adult with a learning disability. One notable exception to this is where an adult requires assessment of their ability to make informed decisions and a formal, defined process exists to respond mandating the involvement of the adult.

It is possible that not only are the views of adults with a learning disability overlooked or ignored but that a supportive relationship or rapport between the practitioner and adults with a learning disability is either non–existent or not recognised as significant. Tew (2006) encourages practitioners to be alert to how the power of their role can be either harmful or productive when applied to their work and decision-making. Where insufficient information is gained by a professional to make an informed decision Tew (2006) identifies that practice has the potential to become oppressive. Where an adult may be experiencing abuse, not asking them about it may contribute to its escalation or continuation.

5.6.2 Not asking further questions where abuse may be indicated

'So on times it's difficult to address some potential issues especially around financial abuse. It's very much of a land-mine

especially for a social worker within learning disabilities'.
Social Worker 21

A number of participants identified with the view expressed by Social Worker 21 and these are recorded in the positional map comments table 5.3. Given that there was a larger volume of comment than anticipated it may be of surprise that this is included as a site of silence. It is included as what remains un-articulated is discretion that participants exercise in whether to pursue indicators of abuse or not. No participant in my study suggested that abuse (however defined) should be condoned or that they personally tolerated abuse. Participants did recognise that asking questions that have the potential to reveal abuse were difficult. Not pursuing these difficult questions is the site of silence; this site of silence is not simply the exercise of discretion to pursue or to not pursue potential abuse but that practitioners in this study have not recognised that they regularly exercise this discretion. Where nurses and social workers choose not ask further questions where abuse may be indicated a personal threshold or personal tolerance to potential abuse develops.

Ash (2010) identified that social workers making adult protection decisions (with older adults) frequently adjust their responses and that their personal thresholds are not consistent or fixed. Evans (2011) suggests that policy and practice are formed when practitioners are presented with dilemmas which are resolved through the enterprise of individual professionals. The views of Ash and Evans reflect Lipsky's (1980) view of street level bureaucracy, that policy and practice are made from the bottom up in organisations by the decisions and discretion that individual practitioners exercise. Evans (2011) offers this description: ' *It (discretion) is the lubricant in the public policy machine. But it is also difficult to control and could overheat the machine'* (p370).

Transferred to adult protection, too much individual discretion in adult protection decision-making could expose adults with a learning disability to additional risk, or reduce choice and opportunity. In Wales, there have been

national responses (SSIA, 2010; Wales, 2014) to promote consistency of adult protection referral practice, through the introduction of threshold guidance and risk rating matrices. Evans and Harris (2004) suggest that more rules or guidance to staff mean more choices – or opportunities for discretion to used. Evans and Harris (2004) add that discretion should be understood as neither good nor bad, simply a characteristic of more guidance, more choices and more opportunities for individual practitioners to apply their own interpretation to practice. Ellis (2011) identifies that street level bureaucracy continues to apply in contemporary social work practice, because of and not in spite of progressive moves towards mangerialism in social care. This, Ellis, (2011) suggests creates greater role ambiguity and with it the likelihood of individual professionals exercising increased discretion.

Where nurse and social work participants have not asked - or recognised the need to ask further questions that may reveal abuse, there is no information with which to initiate a conversation with peers or with a manager. Recognising the previously discussed triggers for identifying abuse and participants' strong association to a hierarchy of abuse (Jenkins et al, 2008), the delay in asking questions may be until sexual, physical or financial abuse is noted. Using positional mapping it has been possible to analyse data from a new angle. A strong emerging theme is that asking difficult questions is avoided; consequently, adult safeguarding action may be delayed until abuse is disclosed or escalates. Noting that these difficult conversations may need to include the family members of an adult with learning disability, the priority to preserve this relationship cannot be overlooked. Preserving the relationship with family members of a vulnerable adult is now explored as a further site of silence.

5.6.3 Preserving the relationship with the family of the vulnerable adult

> *...'she always used to call me... like oh you are like a daughter to me because that is the great thing and the unique thing about working in the (learning)*

> *disability service, particularly a nurse, you are able to work with your families for most of the time for long term you know you are in it for the long haul and you do build up relationships'...* Nurse 13

This site of silence is a development from the positional map in which relationships were recognised to have a high influence upon the decisions of nurses and social workers. In particular, the positional map illustrated that practitioners were less likely to initiate adult protection action if they had what they perceived to be a good relationship with the family of an adult with a learning disability. The site of silence is not the relationship between nurses and social workers and the families of service user-which has emerged strongly and clearly-but that preservation of this relationship is a priority. Maintaining this relationship has the potential to exclude the adult, or to compromise the extent to which their views of are incorporated into adult protection action. This is particularly relevant as the adult with a learning disability has already been identified as a site of silence and the two sites of silence are unavoidably linked.

5.6.2 Conflict with existing literature

The prevailing view in literature over the last three decades is that professionals have failed to work in partnership with family member/carers of adults with a learning disability. In 1997, Witts and Gibson identified that carers were dissatisfied with the information and support provided to them by NHS members of the CLDT. More recently Cairns et al. (2013) noted an *'urgent need to review how parents of individuals with a learning disability and parent carers are supported throughout the lifespan'* (p74). Walker and Ward (2013) advocate that supporting adults with a learning disability to age 'successfully' (p117) will challenge conventional service arrangements and need to support a family as a whole. The CLDT, and nurses and social workers employed in them, are central delivery of these conventional arrangements, with which these authors express frustration

– if not dissatisfaction. Yeandle and Wigfield (2011) advise that the involvement and cooperation of family member/carers is not just desirable but essential to successful service delivery and planning. Yeandle and Wigfield (2011) raise that family member/carers consistently fail to be involved in both of these activities- with their views consequently excluded. This is in direct conflict with the findings emerging in my study.

Relationships between nurses and social workers in this study are described in familial language; Nurse 13 describes that she is considered to be 'like a daughter' to the parent-carer of the service user. Social Worker 3 also refers to 'a cosiness' in the relationship between the family of the service users and professionals. These are not unique comments or anomalous positionsthe positional map has demonstrated that they are common views across the participant group in this study. Given this stated importance of the relationship and the absence of the adult with a learning disability from these conversations, it is not family members in my study who are excluded from decisions but the adult themselves.

The preservation of the relationship with family members, potentially at the expense of the adult, is significant because the comments in my study are not generic or generalised; they are raised in the context of making decisions about abuse. Gould (2010) identifies that left unchallenged, poor quality care and poor practice, which can include examples or indicators of abuse, can lead to norms that become accepted by professionals. Unchallenged poor practice, Gould (2010) suggests may be collusive with the (potential) abuser. Where family norms, views and practices are unchallenged by the nurse or social worker (possibly because they feel that they cannot or should not challenge) the lines of professional practice have become blurred with the potential that they are eventually broken.

Hunter and Rowley, (2015) summarise that *'over time there has been a shift from benevolent but paternalistic approaches that families and professionals 'know best''*(p147) towards a recognition that family members and/or professional may have views that conflict with each other

and with the interests of the adult. To resolve this, Hunter and Rowley (2015) suggest that independent advice or advocacy may be required. To secure this advocacy and guidance the influence of the relationship with the family of the adult would first require acknowledgement- to re – place the adult and the potential of abuse at the centre of practice conversations. The risk in preserving the relationship with family members is that willingly or not the existence of abuse may be minimised, not recognised or deliberately ignored. Whether nurses and social workers are aware that they are exercising a decision not to take adult protection action in favour of preserving a relationship, is not clear. Non–action remains a powerful practice response, whether acknowledged or not. Where this is the case, potential abuse may not be discussed with colleagues or managers. Withholding information from discussions with colleagues or managers is in contrast with the practice identified in this study, principally because the sharing of concerns was viewed as a means of passing responsibility from the practitioner to a colleague.

5.6.4 Not my decision

I wouldn't want to be the person who draws the line in the sand to be honest'... (Social Worker 8)

The polarisation of participant comment as to whether it is the practitioner or their manager that directs or makes a decision about whether to raise an adult protection alert generated clear, polarised views. The volume of comment that indicated that practitioners are not the final decision maker on what action takes place after they have raised a concern with a manager was striking. This contributes to the site of silence in which nurses and social workers in a CLDT do not make decisions about raising an alert about abuse. Nurses and social workers identified that managers–usually Local Authority managers of a CLDT were anticipated, if not expected, to direct the next steps for the query appropriately. Whilst this may be because

individual members of staff consciously avoid making a decision it is also possible that organisational structures and priorities have fostered this pattern of response. Like Social Worker 8, few nurses and social workers identified strongly that they would be responsible for making a decision where they had identified potential abuse. The positional mapping has built upon the initial findings to identify:

- Social workers and nurses anticipate that a Local Authority manager will direct whether a concern about abuse results in an alert/referral being raised.

- Local Authority managers in a CLDT anticipated that concerns were discussed with them and anticipated that they were decision makers as to whether an alert/referral should be raised.

- Where a Local Authority manager was themselves unsure what action to take or where disagreement between a manager and CLDT member was irresolvable, the decision was likely to be passed to safeguarding specialist staff within the Local Authority.

A predominant theme is that accountability for making a decision does not rest with the individual registered professional. This is not to suggest that the practitioner has no views on, or contribution to make to, the situation but that the final decision is not expected to rest with them.

The difficulties practitioners experience when assessing and applying mental capacity to individual practice situations have been well referenced. What was unexpected is the unrecognised effect of confusion and inconsistent understanding of and application of the Mental Capacity Act (Great Britain, 2005) upon responding to abuse. Whilst participants recognised some confusion, the site of silence is that misunderstanding of the Mental Capacity Act (Great Britain, 2005) may reinforce that decisions are not made by the relevant individual practitioners. The comments on positional maps indicated that safeguarding action may be taken (or avoided) as a response to global statements about an adult's ability to make decisions. These statements, especially where these are derived from an assessment by another professional, were largely unchallenged by

participants even where a safeguarding risk was also noted to be present. This negates key principles of the Mental Capacity Act (Great Britain, 2005) that assessments of mental capacity should be time and issue specific and undertaken by the most appropriate professional. As a site of silence 'not my decision' also applies to moving decisions from nurses and social workers to the adult with a learning disability; who once assessed as able to make decisions about their own risk may be expected to live with and manage their own risks.

5.6.5 Summary: sites of silence

Using positional maps to explore emerging ideas, relationships between nurses/social workers and the family of service users were identified as crucial to participants. This revealed that the individual with a learning disability themselves as a site of silence – that their absence in participant interviews was striking. Not only was the relationship with the families of service users significant, but the relationship between participants and managers emerged as highly influential. Applied to practice, the findings of this chapter indicate that making a decision whether or not to raise an adult protection alert is dependent upon a complex set of dilemmas which includes; the recognition of the inter or multidisciplinary practice, the availability of managers with health and social services CLDTs and the extent to which the ability of an adult with a learning disability to make an informed decision about their situation, recognition of abuse and action to be taken.

The next section entitled 'the tipping point: practitioner discretion, management decision' summarises the major influences upon practitioners in making their decisions and how these transfer into individual adult protection practice. This core category emerged from the four categories and is explored in chapter 6 after further mapping and analysis.

Chapter 6. Presenting emerging theory

This chapter has, as its focus, the presentation of the theory that has emerged from the analysis of participant data. Using Clarke's (2005) flexible Situational Analysis method of grounded theory, the experiences of nurses and social workers in a CLDT have been investigated. The findings arising from these investigations are a product of participant and researcher contribution and experience. These findings explore how participants identify abuse and decide whether to initiate – or not - an adult abuse alert, under the *All-Wales Adult Protection Interim Policy and Procedure (*SSIA, 2010) as prompted by *In Safe Hands* (NAW, 2000).

Consistent with the grounded theory method, data collection and simultaneous analysis were undertaken to begin to explore the subjective symbols and meanings identified by participants during interviews. Further to coding using initial and selective codes, the use of situational and positional maps provided an opportunity which, combined with theoretical sensitivity, enabled links to be made between codes and emerging categories. This assisted the development of the data moving emerging themes from participant data to theory.

The use and inclusion of original participant interview data throughout the project provides a link between the experience of individual participants and development of theory. It connects the emotive and challenging topic of adult protection decision-making with analysis and is a reminder to this researcher of the sensitive position of practitioner–researcher to respect the participant data, positions, values and beliefs that they represent within emerging theory.

The constructivist grounded theorist Charmaz (2010), describes that the presentation of emerging theory should demonstrate how it improves, develops and challenges existing knowledge and theory. In Situational

Analysis, a project map presents the theory, highlighting research headlines, with some 'close up shots' (Clarke, 2005, p142) that when viewed together allow an entire overview of the situation to be seen.

Clarke (2005) identifies that the use of a project map to present a new theoretical model is optional, albeit that the map can be powerful illustration of the new theory. For me, as a new researcher, the project map proved supportive to the development of theory and remains faithful to the grounded theory heritage of respecting the core category and the generation of new theory. Project maps, Clarke (2005) outlines, draw together the three types of maps; situational, social worlds and positional:

> *'they are no longer maps furthering one's own analysis but instead are maps tailored to explicate particular aspect of a specific project to intended audiences'* (Clarke, p137).

When researching into how nurses and social workers respond to allegations of potential abuse, the project map assists with understanding the theory and demonstrating the links to practice experience. My project map is a representation of the entire research study designed to be accessible to a wide audience. Clarke (2005) describes that they are most relevant where a situation is complicated and positions nuanced – just as they are in relation to decision-making about allegations of abuse. This chapter presents the project map as a theoretical model of the broad elements of my research and illustrates a range of factors that can impact upon decision-making.

In this study the categories of the official line, expectation and perception, non-adult protection/alternative actions and confidence and competence, contribute towards the core category of the tipping point. Presenting and clarifying the core category – the tipping point - is essential to the development and refinement of the theoretical model and the final project map. As the final step before the development of the theoretical

model/project map, the core category is now presented; it is necessarily influenced by, and not in isolation from, the four categories and associated sites of silence.

6.1 The Tipping point

The Tipping point is presented as the core category for this research project, it recognises, incorporates and responds to the four categories: alternative action/non adult protection action, the official line, expectations and perceptions and confidence and competence as key influences upon decision-making. The tipping point is the decision point at which a nurse or social worker in a CLDT arrives at, and makes a decision whether or not to raise an adult protection alert. The key characteristics of the tipping point can be summarised as: *practitioner discretion management decision*. The characteristics that contribute to the tipping point practitioner *discretion, management decision* are now discussed.

6.1.1 Core category: The Tipping Point – practitioner discretion: management decision

The tipping point, identified as the core category in this research project is the point at which a practitioner makes a decision to raise – or not to raise - an adult protection alert and initiate an adult protection referral. The previous categories have recognised and explored the influences that practitioners recognised as relevant to identifying and responding to abuse. This core category draws together the priorities identified by practitioners and whether to raise an adult abuse alert or not. The core category is accompanied by the theoretical statement: *practitioner discretion: management decision.*

This core category comprises two broader themes:

- triggers for recognising an incident as abuse.

- priorities, considerations and filters that practitioners apply to their decision-making, noting especially negotiation and the influence of relationships with families and managers.

These two themes are significant as the first draws together the prompts that assist nurses and social workers to identify abuse, whilst the second explores how participants rationalise and respond to these prompts. The process of doing so and the consequent decision as to what action is taken is the tipping point for each practitioner. At this tipping point, whether a nurse or social worker recognises an incident as abuse or not as abuse, is relevant. In particular, if an incident is identified as abuse or not, will direct whether an adult protection alert is raised or not.

Identification of the tipping point as the moment in which a nurse or social work practitioner defines abuse and the action to be taken necessitates revisiting the enduring exercise of individual discretion first identified by Lipsky

(1980). Discussing care management decision making in older people's care reviews, Scourfield (2015) describes how discretion can be dispersed between a number of individuals supporting the same adult with each participant forming a different formulation of the situation. Consequently, Scourfield (2015) notes, just as in my study, that incidents of potential abuse are subject to negotiation. This negotiation of the situation by each individual practitioner is an opportunity to define and present (or to withhold) their preferred interpretation to a manager for a decision.

Evans (2015) reiterates that Lipsky envisaged that managers of street- level bureaucrats – nurses and social workers in my research – fulfilled as a primary purpose of their role the function of narrowing the gap between the actions of individual front line staff and the implementation of the desired policy results. This assumes that managers themselves are unmoving and consistent in their

interpretation of local policy and clear in its application to practice. In my research, the recommendations of Social Services managers were universally accepted as the action to be taken; however the views of managers themselves were acknowledged to vary dependent upon a range of organisational pressures.

The number of themes and the need to return to literature and the analysis that have contributed to the recognition and understanding of the core category, have guided that discussion of the core category and is best situated in this chapter. In this way the relational map now presented for the core category – *the tipping point: practitioner discretion, management decision* is a bridge between the emerging findings of the previous chapter and the analysis and presentation of new theory in this.

The relational map for the core category (figure 6.1) recognises the complexities of the experience that nurse and social work participants identified as part of their employment. A strength of the presentation of the core category in the relational map is that it recognises and incorporates the sites of silence discussed in the previous chapter; situating what is articulated with what is not articulated and contributing to a broader understanding of the developing theory.

6.1.2 The tipping point: relational map

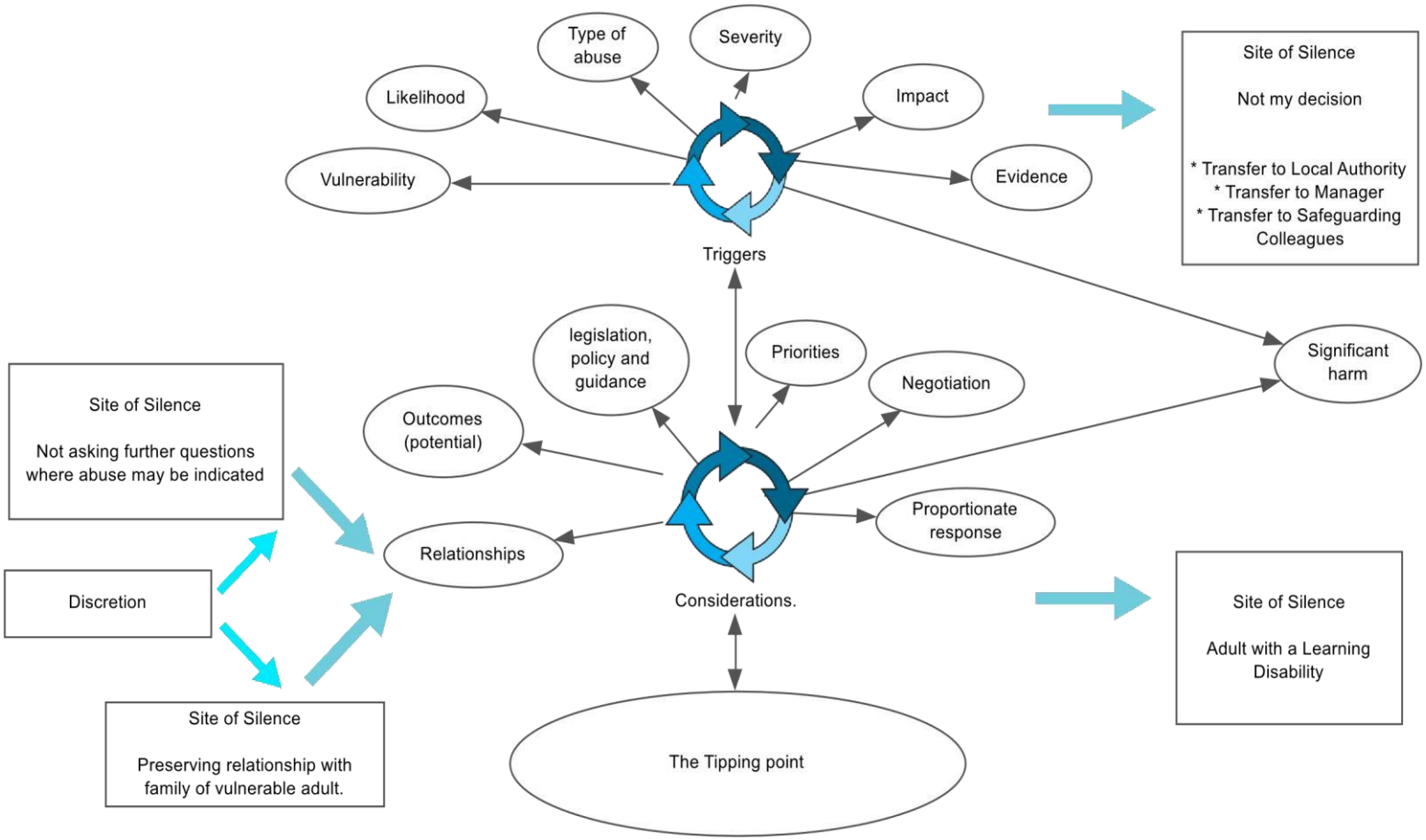


Figure 6.1 Relational map: The Tipping Point

The relational map is the product of refining and re-working the data through a series of initial, axial and selective codes. To clarify this core category, additional detail derived from the initial codes is illustrated on the relational map. This contributes towards a demonstration of the emerging complexity of decision-making and to recognise that the core category is a development of the previous categories. Table 6.1 demonstrates how the characteristics of this category were identified.

Initial codes	Selective codes	Category
Vulnerability, likelihood, immediate action, change in situation, type of abuse, obvious/blatant abuse, impact, severity, situation, evidence	Triggers	The Tipping Point
Proportionate response, negotiation, balance, justice, relationships, potential outcomes, team, team manager, relationships, loyalty, risk assessment, significant harm, priorities, legislation, policy and guidance.	Considerations	

Table 6.1 The Tipping point: Coding themes contributing to the identification of key relations

6.1.3 Triggers for raising an alert

Participants recognised that the existing guidance *In Safe Hands* (NAW, 2000) identifies that a vulnerable adult must be over 18 (an adult), in need or receipt of community services (regular contact with a CLDT may be considered

sufficient) and is otherwise unable to protect themselves from significant harm. *In Safe Hands* (NAW, 2000) outlines significant harm as the threshold for establishing abuse. However, participants identified additional characteristics that assisted them to identify abuse with the significance they attach to them varying. Indeed, as previously acknowledged, the identification of 'significant harm' itself not a single, consistent or universal exercise, is closely associated with the ability or vulnerability of an individual

The increased importance that some participants in this study accorded to some characteristics over others indicated that some participants had a greater or lesser individual tolerance of risk. Despite this, the characteristics considered by participants remained largely consistent. The characteristics that are triggers for raising an adult protection alert are now summarised. Participant comments are included to ensure the link between original data and developing analysis.

6.1.4 Type of abuse and perceptions of severity of abuse

The type of abuse and the suggestion of a hierarchy of abuse appeared in the interviews of staff. Whilst this has been recognised previously (Jenkins et al, 2008) with the priority that nurse and social work participants accorded to this was striking. Social Worker 16 describes that an allegation of sexual abuse is not subject to the same initial screening or risk assessment as other allegations – an automatic referral is made to adult protection (or as previously identified and/or police):

> … (allegations of a) *'sexual nature needs to go straight so any disclosures of a sexual nature even if we think the likelihood is zero that needs to go straight to VA1'...* (Social Worker, 16)

Allegations of physical abuse also feature at the top of the hierarchy of abuse identified by Jenkins et al, (2008) and this was reflected in the in contributions of participants, even where physical abuse and the impact of the physical abuse was unclear:

> … *'And then if it looks like significant harm or abuse, I think significant harm is probably the easier one because in some ways if there is a physical mark there then at least you can say OK there is a physical mark'…* (Social Worker 16)

Social Workers 20, 18 and 11 also indicated that physical abuse required more immediate action than other types of abuse:

> … *'I don't know, say they'd reported that they've hit them or something like that, or something that is really urgent, then you'd have to take immediate action'…* (Social Worker 20)

> … *'you know when it's a clear-cut when if somebody's had an injury, that's definitely, you go in that's a POVA'…* (Social Worker 18)

> … *'I was trying to think of an example, yes, if a member of staff from a supported house if there is an allegation that he has hit somebody'*… (Social Worker 11)

Social Worker 11 continues by clarifying this statement seeming to suggest physical abuse is not only a greater concern in the hierarchy of abuse that but other forms of abuse may not even constitute abuse – or at least not without further clarification or investigation:

> … *'you know that the relative is not abusing them as in physically abusing them, hitting them, they live in squalor you know, it's just very subtle abuse'…* (Social Worker 11)

This echoes the earlier discussion that nurses and social workers referred to blatant or obvious abuse and that this was shorthand for physical and sexual allegations – the two forms at the pinnacle of the hierarchy of abuse (Jenkins et al, 2008). Physical and sexual abuse were perceived to be of a greater severity than other forms of abuse and that these would necessitate an immediate or automatic adult protection alert to be raised. These alerts may be more appropriate for action from, or with, an alternative agency, for example the police, and have been identified as automatically passed on,

usually without further risk assessment. Whether further evaluation and/or multi–agency discussion regarding appropriate response then takes place once the alert has been raised, has not been the focus of this study. The appropriateness of multi-agency responses did feature in the considerations of participants.

The idea that some incidents or types of abuse require an automatic response is also significant in light of the development of the *All-Wales Interim Policy and Procedures* (SSIA, 2010). The guidance directed and encouraged practitioners not to evaluate an incident in absolute terms determined by the incident and the practitioner's perception of the incident; but instead to evaluate the impact upon the individual. Reconciling the incident and the impact of the incident required the involvement and participation of the adult with a learning disability themselves, although Social Worker 18 recognises this, the comment does not indicate discussion with the adult to establish the impact:

> *'…and if you say this is the line, something could still be quite significant to that person'*... (Social Worker 18).

If a worker evaluates that the impact of an incident has not caused significant harm, it is possible that they are less likely to explore the impact of the incident with the vulnerable adult. If adults with a learning disability are not given the opportunity to explore or discuss incidents that at the very least are uncomfortable to them, it is possible that opportunities to identify abuse will be missed. This further reinforces a view that adults with a learning disability may be socialised into accepting abuse and may not recognise it when it occurs, where abuse is recognised by adults they may not believe that they will listened to and their concerns taken seriously (Hollomotz, 2011, Looking into Abuse Research Team, 2013). With fewer opportunities for adults to discuss abuse it is less likely that abuse will be recognised and challenged.

The Looking into Abuse Research Team (2013) noted that emotional abuse - experienced as an adult or a child - continued to have a significant impact

throughout adult life. Given that Reiter, Bryen and Shachar (2007) identified that abuse had a greater emotional impact upon young adults with a learning disability than their peers with no disability, it is likely that the impact of emotional abuse is underestimated. Emotional abuse of adults with a learning disability is therefore likely to be under-reported and prompt a minimal response - if it is recognised as abuse at all. In turn this crucial area is likely to be absent in official statistics relating to adult abuse and therefore overlooked in policy and practice responses. Where the impact of emotional abuse is overlooked, it is less likely to feature in decision-making and consciously feature as an influence at the 'tipping point'. The combination of impact, type of abuse and perceptions of severity have the potential to underestimate or under recognise emotional abuse, although research considering this impact upon adults, is noted to be sparse (Bruder, Kroese and Bland, 2005). Existing adult safeguarding knowledge has, so far, resisted exploring the potential relationships between these sensitive, intertwined and complex characteristics.

As reports of distress following, or resulting from, abuse usually rely upon self - reports (Murphy, Callaghan and Clare, 2007) this may prevent adults who are not able to make their experience known verbally, having their experience recognised. This, in turn, reduces the opportunity for abuse to be recognised or responded to. Reliance upon self – reporting also requires that an adult with a learning disability has the opportunities, communication, support and confidence to both recognise abuse and raise a concern. Even where an adult with a learning disability is able to express their views, it remains possible that this will be seen as challenging or attention seeking behaviour (Hollomotz, 2011, Looking into Abuse Research Team, 2013). It has the potential to create or reinforce a view that the responsibility to recognise and report abuse rests with the adult with a learning disability; this cannot be acceptable for any adult who has experienced abuse.

6.1.5 Evidence

Participants introduced another consideration – the credibility of the account of abuse, preferring to identify triggers for abuse when there was clear evidence of, or a witness to, the abuse. Where there was no witness to the abuse, participants expressed increased doubt about the value of raising an alert. Social Workers 22 and 16 identified that the certainty of having a witness to abuse would be a trigger for making a referral that may not otherwise be triggered:

> … *'I think it in certain situations where um, there was definite evidence of harm, um, or an incident was witnessed by another person, then those things would, would tip the balance '...* (Social Worker 22)
>
> '...*one service user will say so and so kicked me or whatever, but if it hasn't been witnessed by staff it can get quite difficult to really manage it, something like that will go to a VA1'…* (Social Worker 16)

Social Worker 16 identifies the link between an incident being easier to report if it was witnessed, possibly because the adults involved are perceived to be unreliable or unable in their reports of the incident and the type of abuse. Again the absence of the adult themselves is reinforced as a site of silence in understanding the abuse of adults with a learning disability.

If witness of, or evidence of, the abuse is significant in reaching a decision whether to raise an adult protection alert, financial abuse requires further consideration. This is because a conflict is demonstrated between a potential audit trail of financial transactions which can constitute evidence and the views expressed by individual participants. The hierarchy of abuse that Jenkins, Davies and Northway (2008) discuss places financial abuse in the middle of considerations - perceived as less important than sexual and physical abuse and more important than neglect or emotional abuse. Nurses and social workers commented upon discussions of potential financial abuse:

'…you hear of different conversations going on within the team around finances maybe, around service users going on a particular holiday and then you wonder who was the holiday for'… (Nurse 13)

'…especially in our service, allegations can be quite…rife, shall we say…you know, at what level or degree do you say, well, this might be a VA1 – you could have one every day!'... (Social Worker 18)

The comments indicate a number of potential conflicts that a practitioner may experience. These may include doubt about the value of raising an incident that may require further clarification. Further, there is recognition by Social Workers 10 and 18 that financial abuse could be widespread although it is possible that there may be a tolerance of this abuse by practitioners (both nursing and social work) in order to manage the demands of workload, preserving relationships or time that raising concerns may cause. This is in conflict with the guidance of the Nursing and Midwifery Council (2002) who adopt the position that nurses should practice a zero tolerance approach to abuse and that only working in this way to protect people from abuse is acceptable. This position is mismatched with the comments of nurse and social work participants who, described (but did not necessarily recognise) that such a zero – tolerance approach is not their experience.

6.1.6 Likelihood/frequency of abuse.

Not only is the tolerance to abuse by individual practitioners significant to arriving at a decision whether or not to raise an adult protection alert, the pattern, prevalence and frequency of the abuse or incident was also considered significant by participants. In reconciling these elements staff described (but did not state) that an escalation in poor practice or abuse was usually evident before definitive action was taken. Staff may not be aware that what they are describing is how abuse is tolerated. This view relates directly to whether zero tolerance of abuse is realistic. Zero tolerance of abuse may not be achievable because like the participants in this study, professionals do

not recognise abuse at the start of, or an early stage of an occurrence. The word escalation itself was rarely used by any participants although the words likelihood and frequency of abuse were noted. Social Workers 17, 8 and 3 discussed risk and how risks can change and reveal themselves over time, prompting increased concern:

> … *'Well if it's the like second, third or more incident where maybe police have been involved or where there has been concern expressed by other people and the situation hasn't improved despite you know extra support...'* (Social Worker 17)

Social Worker 8 described how escalation can occur within a family setting:

> *'…things literally will creep up, you'll suddenly discover maybe a parent has become seriously too elderly to care for somebody. And making mistakes with medication, so you have those kind of issues will creep up and they will very slowly creep up and at times you'll have somebody who'll arrive at their day service with a massive bruise'…(*Social Worker 8)

If it is common place that no action is taken before abuse escalates, it is possible that abuse is an accepted feature of working with adults with a learning disability. Had participants been posed the question at interview *how much abuse is enough abuse?* it is not clear that participants would have recognised this as a fair or informed question. It is however, how participants responded – referring to a tolerance of abuse and potential abuse. Social Worker 3 described a hypothetical situation relating to a provider, indicating that although physical abuse (typically regarded as more severe than some other forms of abuse) may be a feature of an initial incident it may not be considered to be abuse at the first report.

> (If) *'…someone gets a slap across the face one slap across the face no mark on their face no-one particularly upset it's a one-off it's over in minutes for me that's not a POVA because that's a care management issue … if that had caused a nose bleed or a black eye or a cut then regardless that's a POVA because that's a significant harm if there's not a significant harm and it happens again and there's still not a significant harm for me that a POVA because it's a repeat so they haven't learned from the first mistake so it needs to be addressed more seriously for me'…*(Social Worker 3)

Social Worker 3 does not define the act of slap itself as significant harm – it is only when injuries resulting from further incidents of violence are obvious and unavoidable that it is defined as significant harm and abuse. The type of abuse again featured with the lack of obvious injury being equated to a perception of little significant harm; it is not acknowledged that the one-off incident described could have significant emotional impact upon an adult. If this is the case then waiting for an escalation in physical violence may be too late to recognise and to respond appropriately to, the safeguarding risks affecting the individual. The considerations that nurses and social workers weigh-up, act as priority filters that are applied when making decisions whether to raise an alert or not are now discussed.

6.2 Considerations and priorities for adult protection decision-making

Once triggers for potential adult protection were recognised, practitioners identified that that the available information had to be balanced and weighed. Not all elements relevant to the core category are discussed here as several have been acknowledged previously. Those that are most pertinent to understanding the tipping point at which nurses and social workers make decisions are reiterated here, and contribute to greater analysis and subsequent development of new theory. The characteristics that require additional discussion are: negotiation and including the negotiation to achieve good outcomes and relationships. These characteristics contribute to adult protection decision-making considerations, analysis of which cuts across a

number of emerging themes. These considerations form a series of filters through which priorities emerged that influenced the action that nurses and social workers made.

6.2.1 Negotiation

Participants indicated the potential vulnerability of adults that they were supporting, identifying that adults with a learning disability are likely to experience different opportunities and challenges to other adults. To respond to this difference, negotiation (or discretion to return to Lipsky's (1980) term) emerged as a firm feature of participant's practice. Negotiation was identified as a feature of defining vulnerability, working with providers, families and perceptions of the adult protection process to deliver appropriate outcomes – usually defined as an appropriate outcome for the adult. More subtly, negotiation has been acknowledged to have emerged as critical to exploring or ignoring potential triggers for abuse and whether to raise or withhold (consciously or not) a concern about abuse from a manager.

The certainty of definitions of vulnerability derived from guidance such as *In Safe Hands* (NAW, 2000), is an example that did not match the experience of individual practitioners. The definition of vulnerability when placed in the context of other risks was re-defined by nurses and social workers to secure an outcome that *they* felt would best balance a number of competing risks for the adult. Participants identified that a number of negotiations were required or took place in reaching a decision whether to raise an adult protection alert. The view is particularly relevant as it recognises or reinforces that it may not always be the wellbeing (however defined) of the vulnerable adult that is predominant and instead that the next steps are interspersed with other considerations; negotiations, trade-offs and comparisons.

Nurse 23 provided an example of when they had wanted to negotiate an outcome outside of adult protection procedures that supported an adult and their family despite identifying significant harm:

> *… 'So we were able to say, that this is not wilful neglect, this is just a gentleman whose values and standards are very*

> *different from, from everybody else's, but that he was, he genuinely loved his son and wanted to do the best'…* (Nurse 23)

This negotiation echoes earlier recognition that the relationship with care providers can also be challenging. Whereas care providers are subject to contractual expectations where penalties or sanctions may be applicable and clear, the expectations upon families are more complicated.

The examples within my study are derived from the comments of nurses and social workers who have described that negotiation with families is part of their practice. For Ash (2013) her research explored how social workers saw, and did not see, the abuse of older adults and how instead the difference and discrepancies between expectations and practice reality could lead to abuse being tolerated. Whilst Ash's (2013) research is predominately focused upon abuse in care provider settings this accommodation of abuse highlights the ability of individual professionals to negotiate between risk and action.
Followed to its conclusion, Ash (2013) considers that this 'cognitive mask' or negotiation of abuse has the potential to shift how abuse is defined with the result of raising the threshold at which abuse is reported by social workers. Negotiation was closely associated by participants to securing a good outcome, or the potential of a good outcome, for adults and their families (or in some circumstances care provider). A good outcome applicable to one person in one situation may not be relevant in another situation and reference to achieving good outcomes for a number or all adults may be unrealistic, although it was sought by participants. Individual nurses and social workers expressed a willingness to define, re-define, and if necessary defend their interpretation of a good outcome, according to the situation that they found themselves in.

6.2.2 Good outcomes

Participants identified two distinct directions in relation to outcomes; firstly, the negotiations of individual decisions to achieve good outcomes and secondly, whether the adult protection was believed to deliver good outcomes. These

'good outcomes' were exclusively defined by a practitioner. Social Worker 12 discusses outcomes and individual decision-making:

> … *'I think, personally, professionally it doesn't, it doesn't mean that, it means understanding what it is you do, doing it properly, recording the decisions you make, and the reasons you make them, and understanding what some of the consequences and outcomes of that could be'…* (Social Worker 12)

Like Nurse 24, Social Worker 22 also reflected upon the individual nature of making a decision to secure a good outcome and that achieving that outcome may involve broader considerations and negotiations than the adult themselves:

> …*'so it's trying to achieve a good outcome for all concerned, which isn't, sometimes isn't possible to be done, so sometimes you just have to face up to that and er, you do the best you can, I suppose'…* (Social Worker 22)

The second influence of outcomes is concerned with perceptions about the adult protection process, based upon previous experience. Practitioners reflected that they had experienced both positive and negative outcomes of the process and that this contributed towards their consideration of referring into the process. Nurse 5 explained that their experience had been positive:

> … *'It was quite positive the outcome, the process is good and there is usually an action plan from it which is good and a follow up with people given tasks to do. So, it's been quite positive especially as process has gone on over the years…'* (Nurse 5)

Social Worker 11 shared reservations that decisions made about accessing the adult protection process (always) delivered good outcomes. They expressed that risks managed outside of the adult protection process tended to drift, or be unresolved.

> … *'When it's done well, properly it's good, other times I've seen it done really badly and it's not done and it's an unsatisfactory outcome'… (Social Worker 11)*
> Participants associated the wish to secure good outcomes with a sense of justice – a sense of fairness that all possible options had been pursued. This fairness is identified in the following extracts, not in terms of securing justice by pursuing a perpetrator, but in balancing a number of competing factors. Participants identified that they had direct influence upon balancing these competing factors when working with families of services users and providers and that they were confident and willing to intervene to achieve a situation which was as positive for as many parties as possible. Nurse 9 identified that:
>
> … *'you may have been involved obviously in the development of services and know exactly what is occurring and from the care management perspective what strategies you could put in place to make things right'…* (Nurse 9)

Negotiation of risks may satisfy several possibly competing views but it has potential to overlook that in making safeguarding decisions the risks associated with the vulnerable adult are the primary focus. The sense of balancing competing triggers and considerations and the wish to negotiate good outcomes featured throughout the research interviews. However, just as in the research of Ash (2010), participants in my study found a 'good outcome' difficult to define. The nature of a good outcome is unclear, shifting and subject to change. A recurring theme in my study is that participants identified a number of key relationships as essential to securing or negotiating good outcome, these in turn influenced the ultimate decision that nurses and social workers make.

6.2.3 Relationships

The key relationships that participants identified were with their manager (or management structure), with the family of the service user and to a lesser (or less frequent) extent the adult themselves. The influence and motivation of each of the relationships emerged from the research interviews as very different. Relationships with managers featured as both a source, a support

and authority whilst the relationships with services users and families were predominately defined by references to loyalty. Taken together, a priority of relationships appears to emerge that does not necessarily have the vulnerable adult at the top.

The category, *the official line,* explored the impact of managers on the decision-making of nurses and social workers. It emerged that in connection with safeguarding decisions the managers referred to were usually social services managers and were themselves perceived as part of the 'official line'. Both through experience and through the position held, social services managers were perceived to have both a wisdom and authority which was usually accepted by the nurse or social worker. Where a conflict existed between the view of the practitioner and their manager, an opinion from safeguarding staff was sought almost as a form of arbitration. The identification of a route of appeal demonstrates the authority that (social services) managers hold as the need to challenge the views of a manager were identified as an anomaly.

What is unclear is a consistent pattern by which the relationship between managers and staff develops and influences the decision-making of individual staff. A number of reasons were identified by participants that explained a generally positive appraisal of the role of managers in influencing staff decision-making. The discussion of the role of manager is featured in the official line as to the participants' individual managers represented, or were perceived to be charged with the interpretation of, the national and local guidance. This local knowledge or practice wisdom of managers was valued and respected even if it had the potential to be several years since the manager had been aware of the adult and including situations where the individual staff member had current risk information. The relationship between individual participants and managers was perceived as significant in this study and the relationship remained a formal line of responsibility and accountability. In essence, where staff sought an opinion of a manager it was acknowledged, respected and accepted, with accountability perceived as transferred to that manager.

Relationships with service users and their families were described (if not always acknowledged) as challenging. At times, however, relationships were frequently described using familial language. These were presented in chapter 5 and included terms such as staff being ‘like a daughter’ to the family of adults with a learning disability or staff referring to families as ‘likeable’ or expressing disbelief that family could be the perpetrator of abuse.

These comments refer to the relationship between participants and the families of the service users and generated powerful discussion, especially where their presence excludes a relationship that supports the voice of an adult to be heard.
Comments, all from nurses, identified that trust and responding to the advice of the nurse were characteristics that contributed to a relationship being perceived by them as good or strong.

James (2011) summarised approaches identified by families of adults with a learning disability to be helpful to developing effective relationships with professionals. These valued characteristics included flexibility, consistency, accessibility, availability, reliability, respect, collaboration and effective communication. A strong relationship with family was always perceived as positive in my study, there were no examples in which participants themselves identified that a strong relationship was a disadvantage, even if the adult was potentially excluded as a consequence. Maintaining a good relationship with the family of an adult with a learning disability emerged as a priority for participants, staff were aware that raising a safeguarding issue may have the potential to damage this relationship. The need to raise a safeguarding alert presented as a personal and professional conflict to nurses and social workers. Three responses to managing this potential conflict became evident:

- Negotiating an alternative response to the risk that they had identified.
- Not following up triggers of abuse with questions that might uncover abuse and damage the relationship with the family of a vulnerable adult.

- The action deemed necessary by the professional, was taken, accepting that the relationship was at risk.

The first approach taken by participants acknowledges caution in risking the relationship between service user families and themselves, where there may be a potential indicator of adult abuse:

> … '*So, on some occasions like that we can see it's a relief (that alternative action is taken) because we don't want to see people being put through the process unnecessarily, um, and damaging relationships within families or their care teams or whatever'…* (Nurse 23)

> *'…you know prior knowledge with the history of the person or the personality of the person, sometimes the more you know about them kind of sways the way you react to the VA1 so we try and steer away from that if we can'…* (Social Worker 16) To suggest that participants decline to raise an adult protection concern for fear of affecting a relationship is likely to be an oversimplification. What is undeniable is the clarity with which participants identified the relationship with the service user's family as significant in their assessment of risk of abuse. The comments of Social Worker 21 continue to raise the possibility that where triggers for abuse are noted, no further questions are asked that may confirm or reveal abuse and are a demonstration of the second response:

> *'…it's very difficult because people, they show you the door, say thank you but no thank you. So on times it's difficult to address some potential issues especially around financial abuse. It's very much of a land-mine especially for a social worker within learning disabilities…'* (Social Worker 21)

This approach of not following up triggers of potential abuse was weighed against maintaining ongoing access to the person to monitor the situation therefore valuing the continuing presence of the practitioner above the resolution of potential abuse.

The potential is that whilst triggers of abuse are not pursued by individual practitioners, they are also not discussed with peers or managers; unacknowledged abuse has the potential to be overlooked or potentially

condoned. Like Ash (2013) who researched practice with older adults, the initial findings of my study appear to indicate high levels of individual decisionmaking discretion within CLDTs. This discretion, as Ash recognises, has the potential to adjust individual perceptions of abuse and to re-negotiate or redefine expectations based upon a practitioner's experience. This has the potential to (continually) raise the threshold of abuse based on an individual situation, escalation of abuse, or available resources to respond to abuse.

The following comments indicate the third approach; where a response to an adult protection concern was made and the relationship between staff and family was at risk:

> … '*I think that some families can be…some families can be quite venomous to you if you have had to raise a POVA but others accept that you are looking after the person'…* (Nurse 4)
>
> *… 'I suppose so, that example I gave you I have a good relationship with the family but I have to put the safety of the child (a child in the household with the service user) first. And it was very difficult with the family, they were really disappointed with me'…* (Nurse 5)
>
> *'…having known the family for many years, that the family would be devastated which they were but then it's about working with the family then as well isn't it you know, and trying to pick up the pieces there'…* (Social Worker 14)

Whilst none of the participants identified this as an ideal situation, Nurses 4 and 5 in particular, expressed this in very personal terms and that raising an alert was an indication of disloyalty to the family of the service user. Despite this, one nurse and one social worker expressed that regardless of the relationship with the family of the service user, the expectations of their professional role needed to remain clear. This did not preclude that the responsibility for this decision could be framed as made or directed by Social Services (in the case of health colleagues) or by a manager in the case of individual practitioners. For these two participants the wellbeing of the adult

with a learning disability was more important than the preservation of the relationship with the family and part of their professional role. These participants were alert that relationships could be harmed or damaged by raising an adult protection alert, which whilst not desirable was at times necessary to protect the interests of an individual adult.

The enduring characteristics of the tipping point can be summarised by the theoretical statement: *practitioner discretion, management decision*. This recognises the negotiation that nurses and social workers exercise when recognising and responding to abuse and how this applies to the reality of practice in a South Wales CLDT.

6.3. The Tipping point: Practitioner discretion, management decision

As a decision point, the core category is the result of filtering and prioritising information in the context in which nurses and social workers work. Decision making in this study recognises a range of factors that influence a decision, which may shift and change over time or be dependent upon the situation. Whilst Graham et al (2014) recognise that there is little evidence identifying specific influences upon adult safeguarding decision-making in current literature, this has not deterred efforts to standardise the application of adult protection guidance to practice. Ingram (2011) developed a tool to encourage consistent practice in England, whilst Collins (2010) and SSIA (2010) advocated and proposed threshold decision-making guidance for practitioners in Wales. These tools are proposed to assist practitioners in their decision making-although no evaluation of the success of these has been identified. The use of guidance or tools to establish a single or consolidated threshold for action is relevant as it is in direct conflict with the theory emerging from this study that individual practitioners exercise discretion regarding abuse and that managers direct, or decide if the incident should be considered as abuse. Practitioners may not recognise the amount of discretion that they use in recognising and responding to abuse. It is only when concerns about abuse are recognised that a conversation with a manager will be prompted.

Manthorpe et al. (2010) are unsurprised that that there are different thresholds for responding to allegations of adult abuse and accept this as a characteristic of current safeguarding practice in the UK. Indeed, McCreadie et al. (2008) found adult protection decision-making to be an 'elastic' or fluid concept defined by individual decision-making and organisational priorities with each having different prominence at different times.

The analysis provided for the core category retains a predominant and key presence in the presentation of new theory in the project map. As a representation of the whole project, however, the project map (figure 6.2) illustrates the relationships between the categories, core category, sites of silence and to the theoretical statement: *the tipping point: practitioner discretion, management decision.*

6.4 Presenting new theory: the project map

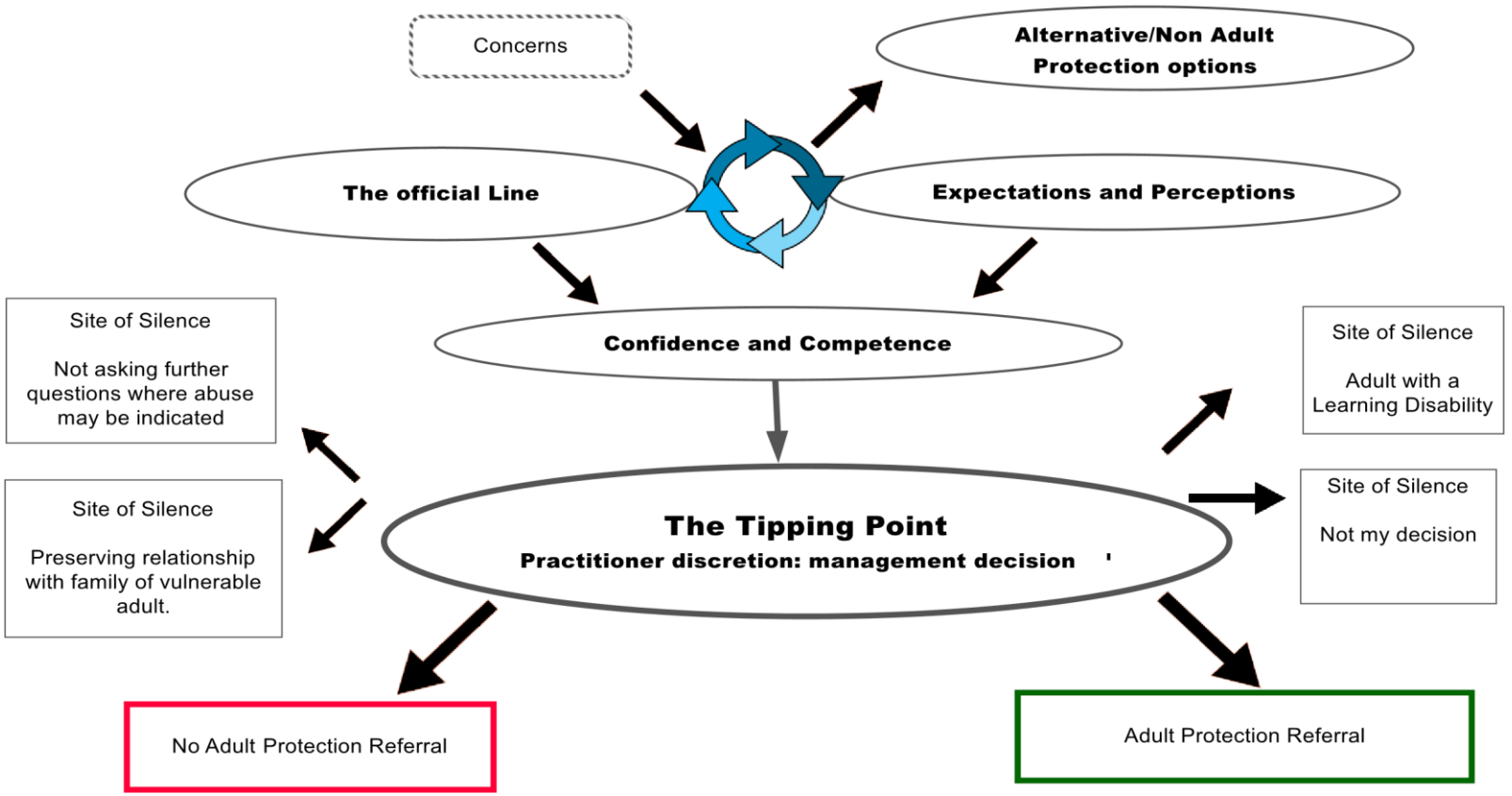


Figure 6.2: Project map - Adult protection decision-making in a CLDT

6.4.1 Explaining the theoretical model: practitioner discretion: management decision

The theory developed from this study recognises the links between the themes that have emerged, and it offers an explanation of how nurses and social workers in a CLDT make decisions about abuse.

Simplified, the theoretical statement that consolidates the emerging themes and priorities is 'the tipping point: practitioner discretion, management decision'. Figure 6.2 illustrates the categories that have contributed to the identification of this theoretical position. Whilst nurses and social workers were aware of, and worked with, the same national guidance (NAW, 2000) this in no way indicated similar responses to potential abuse.

Discretion (and negotiation) were identified as present throughout data analysis crossing a number of categories and conversations. This discretion was not always consciously exercised but was nonetheless present. Conscious exercise of discretion included choosing between the use of the adult protection process and alternative processes. For this reason, the project map presents this category as leaving the map and ending further adult protection considerations. Alternative action outside of the vulnerable adult process was frequently associated with the wish to negotiate a good outcome for a number of parties and to take what was perceived to be proportionate or least invasive action. Referral into the adult protection process generated comment that reflects the now familiar dilemma of finding an appropriate balance between care and control presented as proportionate intervention. Nurses predominately expressed that where intervention was needed to support adults and their families it should be supportive and therefore be the minimum possible effective involvement.

The views of practice expectations expressed by nurses resonated with the Beauchamp and Childress (2013) principle of beneficence – acting with the best interest of the person in mind which may mean not raising a concern - rather than the interventionist stance of *In Safe Hands* (NAW,2000). The

application of the benefice principle to this research study is not without challenge as not accessing the adult protection process could deny an opportunity to achieve an outcome in the adult's best interest. Adherence to the Beauchamp and Childress (2013) principle of beneficence is challenged in this study as acting in the best interests of the person is negotiated or brokered within the wider practice context.

A negative association with raising an adult protection alert was present in participant data and indicated that, where possible, a discretion not to raise an adult abuse alert may be exercised. Participants expressed a link to the perception that if they needed to raise an alert it reflected poorly upon their intervention – potentially as personal failure. Reflecting upon the Beauchamp and Childress (2013) principle of Justice – a concept that emphasises fairness and equality among individuals – participants again expressed values that were potentially in conflict. The principle of justice for the individual is, for participants in this study, situated within a broader context in which the pursuit of a good outcome for a number of parties can impinge upon justice for the individual. Noting that the *In Safe Hands* guidance (NAW, 2000) and subsequent policy direction (SSIA, 2010, Wales, 2014) is intended as a response with the individual adult at the centre, the willingness of participants to negotiate with a number of parties (which may exclude the adult) emerged as striking.

Discretion to pursue, or not to pursue, potential triggers featured strongly during the analysis of participant data. Whether this was a conscious and informed decision varied. Whilst some nurses and social workers chose not to ask further questions where abuse may be indicated, others considered that they knew the family situation well enough to independently assess and negotiate the presenting risks without requiring additional information and/or support. The accuracy of this assessment was not explored in this study it is simply acknowledged that nurses and social workers identified this as a characteristic of their practice. It cannot be overlooked that preserving the

relationship with the family of the adult with a learning disability emerged as a powerful influence upon practice. In preserving this relationship, increased negotiation was present; most usually in this negotiation no person external to the situation was involved. Comparisons with child protection practice were raised by participants again prompting consideration of the care and control balance but also a recognition that adults with a learning disability can be viewed as 'eternal children' (Wolverson 2011) and excluded from decisions about their own lives.

Equally, whether participants recognised it or not, delays in forming or reluctance to form an assessment of risk that resulted in no action being taken had the same effect as exercising a discretion to tolerate potential abuse. Where nurses and social workers assess and define risk themselves and do not to raise the issue whether - through a formal adult protection process or informal discussion – a discretion to tolerate potential abuse has been reached.

The willingness of nurses and social workers to exercise discretion is in conflict with the expectation their managers – that is social services managers decide. The position of the categories, *the official line* and *expectations and perceptions* in the project map, are significant as the two categories necessarily interact with each other. Whilst the official line may have been anticipated to have comprised legislation, guidance and local policy it emerged in this study to also include managers – whose guidance and direction was accepted *as if* or as an interpretation of the official line. For participants, managers were considered to be translators of policy and guardians of the application of policy to practice. Participants identified that not only were managers guardians of local practice, they were also the decision maker, relying upon local and historical knowledge of families known to the CLDT and directing the practitioner whether or not to make or raise an adult abuse alert. Evans (2010) disputes Lipsky's primary interpretation of the role of the manager as enforcer charged with reducing discretion and identifies that

working (potentially) at just one job role removed from individual practitioners' managers are also likely to exercise discretion. Acknowledging the theoretical statement practitioner discretion, management decision, there is no indication that participants in my study recognise manager decision making as anything other definitive.

In the context of this study, managers emerge as decision makers but as Carson, Chung and Evans (2015) remind, their views are formed by organisational and intra-organisational priorities and discretion. These organisational priorities may account for practice variations between agencies even where a shared responsibility (such as safeguarding) exists. In my study, even where there was no formal directive from managers to participants, there was a perception that managers had the final say on whether an alert was raised.

This view was reinforced by both the perception that this was the role of social services managers and an expectation that this role would be fulfilled by social services managers. Once a concern about abuse was identified the next steps, whether formal or informal were firmly associated with Social Services. This echoes the findings of Northway et al (2007) - despite the direction of safeguarding in the intervening years being that safeguarding is everyone's business (HIW, 2010, SSIA, 2010). The 'safeguarding is everyone's business' message and the responsibility for the approach has little evidence of being adopted into the practice of nurses and social workers in this study. Policy and legislation advocates a multidisciplinary approach and there is some (albeit mixed and limited) evidence to suggest that multidisciplinary work can be beneficial to safeguard adults (Graham et al. 2014). The picture of this research study is far more mixed, participants expressed good day to day relations between nurses and social workers; although these could at times become strained. In particular, the relationship between nurses and social workers presented as unbalanced in the context of adult protection practice: nurses anticipated that social workers and their managers were an available

resource wherever a potential adult abuse concern was identified. The stated position repeatedly raised by participants was that as the lead agency for safeguarding, Social Services had the responsibility to direct, coordinate and decide upon the action required to respond to allegations of abuse.

This is not to overlook that there were a small number of nurses and social workers who felt confident to make decisions about abuse. Frequently this confidence was associated to holding a supervisory role within the CLDT or an additional role within the safeguarding process. No assessment or comment is made about the competence of individual participants to make decisions as this was not the aim of the research, rather this category is positioned in the project map as a filter. As a filter, confidence and competence is the point at which practitioner discretion and management decision both merge and separate. Nurses and social workers may well feel both confident and competent to manage risk information or withhold it from being considered as abuse. However, it is more likely that this is done unconsciously but not unthinkingly. Nurses and social workers who do not recognise or do not respond to potential triggers of adult abuse are not then likely to have enough information to present to a manager, for them to consider whether an adult abuse alert should be raised. This reinforces the theoretical statement that at the tipping point practitioners exercise considerable discretion. More consciously (and frequently), participants indicated that however confident they were in their own ability there was no discretion as to how they directed their concerns; safeguarding decisions *are* management decisions.

6.5 Implications of this theory for safeguarding practice

This theory introduces new implications for safeguarding practice; it highlights that managers, or at least social services managers, are currently positioned as custodian of adult protection policy. Moreover, nurses and social workers emerge in this theory as not being the main decision maker, deferring this to social services managers. By use of sites of silence, the emerging theory illustrates that consciously or not, practitioners may choose not to pursue

incidents of potential abuse. The effect of not acknowledging, or withholding this information from managers – who are acknowledged as decision makers – may mean that abuse is not recognised or raised. For safeguarding practice there is a very real implication that nurses and social workers do not recognise themselves as decision makers when they identify situations that may be abusive. The new theory presented has implications for practitioners in being alert to how abuse is defined, and that this re-definition may deny some vulnerable adults the opportunity for their situation to be understood and abuse responded to. Emerging as key personnel in decision-making being alert to this theory is essential to managers both within Local Authority and NHS settings to acknowledge how concerns are predominately addressed to social services, potentially bypassing or ignoring appropriate health based responses. Without exposure to adult protection concerns and decisionmaking NHS colleagues may not be able to make a complete and informed contribution to the safeguarding of individuals. Whilst policy makers may be unaware that at the tipping point of adult protection decisions practitioners exercise discretion whilst managers make decisions, the need to promote this awareness through education is a theme developed as a recommendation in the next chapter.

The influence of relationships with the family of service users emerged as highly significant. This relationship influenced the extent to which potential abuse was likely to be explored, with one characteristic of this being whether or not nurses and social workers *liked* the family they were working with. This relationship had the potential to be contrary to the principles of the Mental Capacity Act 2005 (Great Britain, 2005) in which professionals are required to assume that an individual can make a decision until assessed otherwise. In safeguarding practice, this is a reminder to involve and value the adult themselves in a conversation about their own abuse. Despite the identification of the value of a conversation with the adult about their experience of abuse being noted, the adult themselves is largely absent from participant comments and consideration. Failure to explore, acknowledge and respond to

experiences of abuse, in a timely manner has the potential that nurses and social workers collude with abuse and no action is taken; at least not until the abuse escalates – typically into physical or sexual incidents.

6.6 Summary

This study has critically compared and contrasted existing literature as to the findings raised through participant data and a theory devolved from the consolidation of this information. This is consistent with the grounded theory method (Strauss and Corbin, 1998). Emerging as key to the theory is; *the tipping point – practitioner discretion, management decision*, several reasons for this have been presented. Discretion, at a number of stages of nurse and social work practice, was noted, however the exercise of this discretion was less readily recognised – if at all in some circumstances. Not only did this have the potential to deny adults the possibility of having their situation considered through the lens of the adult protection process, but it also denies the rights of an adult to make unwise decisions which are now enshrined in the law of the Mental Capacity Act 2005 (Great Britain, 2005). Involving an adult in their own decision-making also emerged as discretionary with the emerging themes from participant data reflecting involvement of the adult in decisions about their own abuse as the exception rather than the rule. The willingness of nurses and social workers to protect and defend a relationship with family members emerged strongly. The strength of the data supporting that the family of the adult with learning disability predominately makes decisions on behalf of the adult was unanticipated.

Consistently returning to the participant data and literature enabled greater familiarity with the emerging themes from the data, especially with the development of theory that managers decide and direct the action to be taken when concerns about abuse are raised. The use of mapping indicated that there were a number of overlapping links between emerging key themes and confirmed that there are complex and enduring practice characteristics present in several. Far from devaluing or diluting the emerging theoretical

statement *the tipping point: practitioner discretion: management decision,* the presence in several categories of these themes serves to strengthen the relevance of the theory. The experience of individual nurses and social workers was not simply one of following legislation, guidance and local protocols. Participants responded to the situation in which they found themselves taking the initiative (rightly or wrongly) to challenge formal process and practice as they most felt appropriate. Responding in this way, participants identified no conflict with their status as registered nurse or social work professionals, partly because the levels of discretion exercised were not recognised. Where abuse was recognised, conversations were quickly held with a social services manager in order to take direction and to move responsibility for a decision from the individual practitioner to Social Services.

Whilst some findings of this study reflect themes that have emerged from elsewhere in adult protection literature, some findings have emerged for the first time in this specific context of exploring the practice of nurses and social workers who work in CLDTs in South Wales. Literature researching the English, UK or international context is likely to overlook the specific details and experience of working in devolved Wales with a political landscape that is increasingly distinctive. Original research findings have emerged in this study and this original contribution will be outlined in the next chapter.

A key characteristic of this study is that there are clear, new themes that have a direct relationship with current adult protection practice decision-making in a CLDT. The emerging findings and theory presented include priorities for adult protection practice. The following chapter draws conclusions and makes recommendations for practice, policy, education and research based upon the emerging evidence from this study.

Chapter 7. Conclusions and recommendations

This chapter reflects upon and reviews this study, this researcher, and the limitations and strengths of the work. It presents the conclusions of the study, and then, continues with a review of the implications and recommendations for future research, as well as for nurse and social work education, training and practice. This chapter also presents and highlights how this study makes an original contribution to knowledge.

7.1 Key elements of this study

This study has sought to explore the experience of nurse and social workers in a CLDT. The specific objectives were to establish:

- Influences upon social worker and nurse decisions that relate to adult abuse/adult protection.
- Why action is taken / not taken when abuse may be indicated.
- Nurse and social worker experience of working together to respond to abuse.
- Nurse and social worker perspectives on how legislation, policy, and guidance are used to assist in responding to abuse.

Using Clarke's (2005) Situational Analysis version of constructivist grounded theory 'the tipping point – practitioner discretion: management decision' emerged as the core category. The core category recognises that a number of motivations and influences contribute to a practitioner reaching their own personal tipping point. These influences are the identified categories:

- The official line (policy, legislation and guidance).
- Expectations and perceptions (of self/other professionals).
- Alternative/ non vulnerable adult options.

- Confidence and competence (perceived or real).

Before drawing together conclusions, it is important to consider the role and development of the researcher and the limitations and strengths of the study.

7.2 The practitioner/researcher role

Holding the role of practitioner and researcher in a challenging research study has brought with it some additional considerations and intense personal reflection. I am a practising registered social worker working in a Local Authority – albeit not a CLDT. In addition, as a registered social worker, I am involved in adult safeguarding decision-making and practice largely from the perspective of trainer, investigator or Designated Lead Manager – a role that only exists once an adult abuse decision and alert has been raised. I have held this role under the local policy and *In Safe Hands* (NAW, 2000) policy and since the introduction of the All–Wales Interim Adult Protection Policies and Procedures (SSIA, 2010). These safeguarding roles have been maintained through the life of this research, so I had an awareness of local, anecdotal conversations about the application of thresholds to practice. I was also aware that I held preconceptions, expectations or personal preferences as to what practice (good or bad) looked like once an adult had entered the adult protection arena. What I was less aware of, were the dilemmas and discussions of practitioners that preceded an adult protection referral and attempts to determine a decision-making threshold. Presented in policy, guidance and training as a clear, certain, and linear process this had not been my practice experience. I was acutely aware that adult protection had a recent history not founded in legislation and similarities with child protection may be unhelpful. Even before the start of the project I had challenged social work students I was supporting, to consider the statement that 'child protection is easy!' when compared to adult protection. The statement recognises the complexities of no specific legislation, assessment of mental capacity and the role of consent in adult protection practice.

From the start of this research I was aware that it would not be possible to be entirely detached as a researcher in this project (Fook, 2000). Lee – Treweek and Linkogle (2000) identify that there can be 'danger in the field' (title) for the practitioner – researcher notably that holding two roles can become an emotional, ethical and professional risk. Whilst ethical approaches can be reviewed and planned in advance of meeting participants, dissonance between existing knowledge and practice and the themes may arise whilst undertaking research. These differences can be sources of professional conflict that impact upon the emotional wellbeing of the researcher. Indeed, in the paragraph below, this very situation is acknowledged. As well as the challenge of my research being in an area of existing practice, in the practitioner-researcher role there are additional complexities to consider.

McDermid et al. (2014) adds that 'research involving peers and colleagues has received relatively little consideration in the literature' (p28) and that it is possible that the practitioner-researcher carries additional emotional responsibility and a burden of increased scrutiny. Undeniably, the position between the practice and research has been challenging and at times lonely. This practitioner – researcher position requires further discussion.

7.3 Reflexivity in my research

Aware that I held views gained from my own experience as a social work practitioner, I reflected critically on them throughout the research study. I included dilemmas and conflicts in my theoretical memos, both to reference and to explore these differences, and to be alert to where in the development of theory these occurred. The place of reflexivity in and the flexibility of,

Clarke's (2005) Situational Analysis contributed to the identification and choice of the approach. Clarke does not assume that practitioners are unaware of the subject that they are researching – indeed, she queries how a researcher without this awareness can understand and respect the experience of participants. Immersion in the data during interviews, through reviewing

transcriptions, coding and mapping were all opportunities to explore and challenge my pre-existing views. These were also discussed and explored in supervision, noting that members of the supervision team all had both practice and academic experience. Fook and Askeland, (2007) add that challenging embedded assumptions is essential to developing reflective, and therefore safer, practice. Osmond and O'Connor (2006) reflect that knowledge–based care is an increasing responsibility or expectation upon social workers; taking this approach firmly links practice and research. Undertaking this research study has challenged, prompted and developed my awareness of my own practice, existing literature and research methods/analysis.

There are findings from my research that have at times surprised and challenged me. Examples of this include the identification of strong loyalty to the family of adults with a learning disability and the willingness to protect this relationship, to the extent that potential triggers of abuse were not pursued. This position was echoed in the site of silence, that adults were frequently excluded from discussions and decisions about their life and the abuse that they may experience. At odds with policy direction for both safeguarding practice and working with adults with a learning disability (NAW, 2000; SSIA, 2010; WAG, 2011; Wales, 2014), the absence of the adult has been both significant and challenging to me as practitioner – researcher. Indeed, the significance of this absence directed me to return to the original data several times to challenge both myself and the data, to confirm this emerging theme. As a registered social worker, I am aware that the revised code of practice (Care Council for Wales, 2015) makes explicit commitments to identify, raise and respond to the risk of harm with paragraph 5.1 clarifying that social care staff must not directly or indirectly abuse, neglect or harm individuals, carers or colleagues. The findings of my research have prompted me to reflect upon these expectations. Given increased moves towards the professionalisation of social work, the relatively recent introduction of registration and the revision of the code of practice for social care workers (Care Council for Wales, 2015),

the new theory - ‘the tipping point; practitioner discretion, management decision’ appears counter to these developments of professional standards.

The willingness of practitioners – from both nursing and social work – to exercise both considerable discretion and to seek management endorsement of their practice presented an unexpected polarisation of professional practice. This polarisation prompted conversation in supervision to discuss, confirm and reconcile the strength of this finding. These findings do provide evidence to inform practice and to recognise the complexity of the practice situation that nurses and social workers in a CLDT find themselves in. This can include lack of, or competing legislation, conflicting guidance and shifting local priorities and resources.

Exploring, through mapping, the micro and macro conditions that influence safeguarding decision-making has prompted deeper analysis and understanding of nurse and social work practice. This includes extending my own appreciation of the conflict, dilemmas and trade-offs that nurses and social workers experience in practice. As a practising social worker, there is an undeniable interdependence between research and practice, with each enhancing and supporting the other to improve the experience of responding to abuse of adults with a learning disability. Undertaking this research has reinforced for me that a separation between research and practice is likely to be artificial, and confirmed my commitment to contributing to the adult safeguarding evidence base. The findings of my research are important for safeguarding practice in South Wales and have prompts for wider practice both in and beyond Wales. Pursuing these prompts requires that additional research and publication is undertaken to ensure that the priorities identified in this study continue to contribute to safeguarding practice. The introduction of the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) due for implementation in 2016 and introduction of adult safeguarding legislation within it reinforces the timeliness and relevance of this research to the Welsh social policy landscape.

7.4 Limitations of this study

As a new researcher, I had no previous experience of using grounded theory or coordinating a research project. Semi–structured interviews in this research required a significantly different skill to my professional practice. Whilst this developed during the study, it is possible that it limited the richness of the information gathered, especially in the early interviews. As themes, and my skills, developed, I felt more confident to explore, clarify and confirm the views of participants which challenged any potential ambiguity.

Recruitment for the project was slow and time consuming. In discussion of the study at CLDT team meetings eligible potential participants identified that committing to an interview was too difficult. One stated reason was the time involved and that staffing within teams meant that they were required to provide cover for colleagues covering duty, sickness or leave. It is possible that the sensitive nature of topic deterred nurses and social workers from participating for the fear of expressing a 'wrong' opinion. One participant indicated in their interview, that they felt that research had a history of engineering findings and misrepresenting participants. It is possible that similar views deterred potential participants despite a number of ethical safeguards being in place. Whether this influenced participants' decision to participate in or avoid being included in the project is unclear. Participants were aware from the participant information sheet that the researcher was also a social work practitioner – although this research was independent of any employment. It was certainly not promoted as an incentive to participate and reference to this role was not incorporated into any research interview. The need to secure enough participants to enable data saturation to occur, was reached by extending the initial geographical area of the study, which introduced greater variations in local practice. These are, however, recognised and addressed during this study, including that this presented an opportunity to consider wider perspectives and be alert to local differences.

The grounded theory methodology traditionally has a perceived weakness of a lack of generalisability of findings, because projects tend to be based upon specific settings, for example, a CLDT. However, the aim in grounded theory is not usually to generate generalisable results – but to examine a specific situation. The intention of this study was to explore the views of individual members of the CLDT within the context of practice in Wales. This understanding, rather than the generalisability of findings, was the focus of this grounded theory study. This study does not address, or set out to address, wider issues that may influence, or may impact upon, CLDT practice. Equally, whilst the key principles the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014) were known, the code of practice to support the implementation of the safeguarding requirements of the Act were not available. This thesis is written, acknowledging that these details were awaiting publication. There are, for example, no discussions of how education, the training of staff or economic status in the participant areas may shape the landscape of health and social care in Wales. This study provides an insight into the reality of influences upon nurse and social work safeguarding practice; it includes and appreciates the first hand contribution of these participants.

7.5 Strengths of this study

This study has a number of strengths both linked to the constructivist grounded theory methodology of Situational Analysis and to the conduct of the project. Situational Analysis (Clarke, 2005) applied a flexible approach to data handling, to coding and mapping, leaving with the researcher the decision whether or not to produce a final project map. Flexibility should not be misunderstood as in-discipline and Clarke's (2005) approach remains loyal to the foundations of grounded theory and to developing credible, clear and transparent research.

The flexibility of Situational Analysis allowed me to balance a number of methodological and practical issues. Where there was an opportunity, I

undertook several interviews on the same day, as this was convenient for individual participants. Reflection took place during and between interviews and it was possible to adapt interviews to challenge and test out ideas with participants on the day. Whilst this is a challenge to traditional views of strictly adhering to constant comparative analysis, taking time away from the interview to reflect upon emerging ideas was effective for testing out and challenging ideas.

Theoretical sensitivity was consciously used in interviews but was most evident on the days in which several interviews took place. Interviews evolved to respond to the emerging themes whilst there was also an opportunity to identify and explore issues that appeared to be based upon regional direction and interpretation. After every interview, I wrote field notes which contributed to a personal reflection and theoretical memos, each activity being consistent with constructivist grounded theory. This reminded me that data analysis is a product of the combined contributions of participants and researcher. For some participants, the interviews were emotive and I was reminded of the privilege of researching in the sensitive subject of adult protection.
Participants' trust in me to manage the interview (the participant's decision was to complete the interview, despite opportunities to stop) and to respond appropriately indicated that a rapport had been established.

As a practitioner – researcher there were additional complexities in the role that have already been referenced. It is a strength of this project that this was shared, known, and reiterated at the start of each interview. Participants were all aware that this dual role required that in the event of a disclosure of abuse this would need to be explored. I was aware that this may have been viewed as a power imbalance, making roles and disclosure routes known in advance was to be open and honest with participants. I was mindful that participants (especially social workers) may see me as an 'insider' or kindred spirit. Oakley (1981) noted that characteristics shared between interviewer and participant

– she noted gender – may assist participants to contribute more willingly. This was not my intention by disclosing my professional background.

To ensure and demonstrate academic rigour during the project, developments were discussed in supervision. Coding decisions identifying the emerging themes were discussed and challenged in supervision. A number of interviews were coded by researcher and supervisor in isolation from each other, and the identified codes compared. As situational, relational, social worlds/arenas and positional maps these were drafted and re-drafted, audited, discussed and tracked through version control.
These, too, were discussed in supervision, at early career conferences and challenged through theoretical memos to reference and record the reasons for the re-drafting of the maps. At each stage, the decisions made can be traced and scrutinised. It is a strength of this project with situational analysis and associated maps that the complexity and messiness of adult protection decision-making can be traced and displayed. The project map is the culmination of data analysis, theoretical memoing, challenge from constant comparative analysis and supervision; it is the product of constant review, challenge and change. This rigorous approach to data analysis, review and development of new theory has contributed to new knowledge in adult safeguarding practice.

7.6 Original contribution to new knowledge

This study has identified that there is a lack of literature, knowledge and research relating to influences upon adult abuse decision-making. The lack of or 'gap' in the literature was particularly evident in examining and comparing the experiences of nurses and social workers practising in Wales in the specific context of CLDTs. The focus of this study was to address this 'gap' in existing knowledge, to understand what influences nurse and social worker decisions to recognise and respond to abuse, and to develop a grounded theory. Adult protection is an evolving area of practice with a short formal

history with (new) legislation due to be implemented into practice in 2016. The timeliness of this research is relevant to the development of practice to support current guidance and proposed legislation. Referring to aims and objectives of this study; how nurses and social workers define, re-define, recognise and respond to abuse has been explored. This has provided evidence that nurses and social workers exercise considerable individual discretion to recognise or deny the presence of potential indicators of abuse. In so–doing potential abuse may not receive a review of risk that is proportionate to the situation or involve key multidisciplinary colleagues and discussions.

Whilst valuing a relationship with family members was a characteristic that appeared in the practice of nurses and social workers, differences in both interpretations of guidance and perceptions of the roles of NHS and Local Authority staff demonstrated a clear split. Predominately the responsibility for adult safeguarding practice was anticipated to be the responsibility of Social Services, including at the stages of identification of abuse – an informal stage prior to raising an alert to the attention of the Local Authority to pursue the adult protection process as *In Safe Hands* (NAW, 2000) prompts. Working together to respond to abuse across health and social care was not a strong theme. Whilst pockets of inter-disciplinary practice were noted and valued, Social Services emerged as the expected custodian of adult safeguarding practice - the agency with which responsibility derived from *In Safe Hands (*NAW, 2000), ultimately rested. This perspective was shared – albeit not without comment – by nurses and social workers.

The sites of silence identified in this study offer a unique opportunity (provided only by the use of Clarke's (2005) Situational Analysis to understand the key influences or priorities upon nurses and social workers' decision-making when potential abuse is acknowledged. Situated in CLDTs in South Wales, the experience of these participants has added increased understanding of safeguarding influences in this region of Wales.

Participants identified unique features of working with an adult with a learning disability, the opportunity to be involved as a professional over an extended period of time and to build an enduring rapport with service user or, more often, their family member or carer. Awareness of the family situation of adults with a learning disability featured strongly as a characteristic when discussing assessment or negotiation of risk. In assessment of risk and in deciding whether to pursue or deny the presence of potential abuse, both the articulated and unarticulated views of participants are helpful. The articulated views that an adult with the ability to make an informed decision should have the opportunity to do so, were embedded in the practice awareness of participants. The unarticulated view is that adults with a learning disability, especially those living with or in contact with their family members as carers, as likely to be viewed as 'eternal children' (Wolverson, 2011 p326), and are less likely to have their views recognised in favour of the proxy decision-making of their family. It has been recognised in this research that this can lead to the non– identification of, or tolerance of, adult abuse. Where practitioners exercise discretion not to enquire further about abuse, there may be a denial of support to the adult that would otherwise be available through the safeguarding process, and a reliance upon the individual practitioner and their ability to manage safeguarding situations unilaterally. Whilst the impact of abuse is personal to the individual adult (SSIA, 2010), the concept of 'significant harm' (NAW, 2000) is the current threshold for responding to abuse; social workers and nurses in this study described that they re-defined this threshold so that abuse was not identified. Presented in the existing adult protection guidance (NAW, 2000, SSIA, 2010) that there is one discrete decision-making point at which abuse meets the threshold for raising an alert, this was not the experience of participant nurses and social workers.

The original contribution to knowledge is a theoretical model that recognises some of the factors that impact upon and inform adult safeguarding decisionmaking, including that when individual nurses and social worker

practitioners become aware of potential adult abuse they exercise considerable discretion as to how to respond and that managers will make final decisions about what action is taken. The theory developed from this study contributes towards an appreciation of the dilemmas, conflicts and negotiations that nurses and social workers experience when safeguarding adults with a learning disability.

Using Situational Analysis (Clarke, 2005) to understand the practice situation of nurse and social work participants it became clear that micro and macro influences were most prominent in the practice experience, although mesolevel influences could not be denied. Macro-level influences of the Mental Capacity Act 2005 (Great Britain, 2005), for example, featured significantly whilst the micro-level influences of colleagues, peers, service user family members and management were also recognised. This study has also recognised and explored the meso–level influences of local procedures and local configuration of health and social services organisations. It cannot be ignored that these meso-level considerations are themselves influenced by macro–level conditions such as *In Safe Hands* (2000) or the *All–Wales Interim Policies and Procedures* (SSIA, 2010) albeit that these considerations may be subject to interpretation in a local or regional context.

There is a need to recognise that my emerging grounded theory has the potential to identify a conflict with current practice, and that this may be in conflict with policy and practice direction, identifying a gap between policy and practice. An example of this is the policy and practice aspiration of personcentred practice; whereas this study identifies a focus upon valuing the relationship with family members of an adult with a learning disability.

This study also recognises the complexity of practice with adults and that recognising and responding to potential abuse is not straightforward. Risk assessment and subsequent decision-making in this study were filtered through a number of layers of local practice, relationships, personalities and

management preferences. Some CLDTs in this study responded to alleged abuse through non-vulnerable adult procedures; this was often determined by perceptions of the severity of the incident, whether there was a more appropriate response such as police involvement or by existing high volumes of adult protection work. The threshold of identification or threshold of tolerance of abuse is therefore flexible over time and incidents, as well as responsive to relationships and personalities.

It was recognised prior to this study that achieving coordinated responses from health and social care are not always straightforward and safeguarding action was predominately viewed as a social services responsibility (Northway, 2007). Despite fifteen years since the introduction of *In Safe Hands* (NAW, 2000) in Wales, this study confirms that adult protection practice continues to be viewed predominately as a social services activity. The continuing presence of this view, in this study, is particularly relevant given that inquiries into the contribution of registered nursing staff to institutional abuse at Staffordshire NHS Hospital (Francis, 2013) and Winterbourne View private hospital (Flynn, 2012) coincided with the lifetime of this study. A reluctance to make individual decisions and to be individually accountable for them, characterised a potential individual paralysis of action in both hospitals. In my study the new theory – the 'tipping point; practitioner discretion, management decision' also proposes that participants identify that managers are the gatekeepers of safeguarding action and decision makers where adult abuse was noted; and that delay to achieve this decision was routine and accepted.

This study has enabled a new and relevant insight as to how nurses and social workers experience and apply policy, guidance, professional and practice expectations that are filtered through UK, Welsh and local interpretation and priorities. The contribution to new knowledge that this study makes, enables the proposal of a number of recommendations to develop safeguarding responses for adults with a learning disability.

7.7 Recommendations

Further to the identification of new knowledge and prominent themes in this study, the following recommendations in relation to research, social work and nurse education, policy and practice are proposed. The priorities and characteristics presented in my theoretical model (chapter 6) are the source of the evidence for the commentary and prompt for recommendations. These recommendations are especially relevant to the areas of research, nurse and social work education, policy and practice.

7.7.1 Research

- That the absence of the adult with a learning disability from conversations about their experience of abuse requires urgent exploration to investigate why adults are excluded from decisions about their lives and safety.

- That further research as to how abuse is defined as significant harm (or not) is undertaken. In addition, to this–further research to explore the action that parent/family carers see as most appropriate, is timely.

- That further research into the influence of relationships between nurses and social workers and management upon safeguarding practice is required. In particular, the characteristics that nurses and social workers value in managers making or directing decisions (and potential disagreement) requires further investigation.

- That the motivation to preserve the relationship between nurses and social workers and the family of adults with a learning disability – even if potential abuse is identified – requires further research.

- That the impact of the proposed changes in the Social Services and

Wellbeing (Wales) Act 2014 (Wales, 2014) requires research to monitor changes in practice approach/ownership of adult protection decisionmaking.

- That a similar research project is carried out, expanding beyond South Wales to examine patterns of decision making across all of Wales.

7.7.2 Nurse and social work education

- That professional education should equip practitioners with the skills and knowledge to ask difficult questions in relation to safeguarding.

- That professional bodies – Care Council for Wales and Nursing and Midwifery Council - note findings of this research and links to professional codes of practice. This is especially relevant in relation to professional boundaries and the requirement to respond to abuse and neglect and to define standards for professional education.

- That post qualifying training for nurses and social workers develops safeguarding knowledge to ensure that expectations and responsibilities of the Social Services and Wellbeing (Wales) Act 2014 (Wales, 2014), for example duty to report abuse are known.

7.7.3 Policy

- That it is recognised by Welsh Government that safeguarding practice is not straightforward and that policy may not recognise the complex nature of both decision making and abuse. It presents a picture that adult safeguarding is a straightforward, linear and consistent process. Guidance and codes of practice may be strengthened by acknowledging this complexity.

7.7.4 Practice

- That nurses and social workers ensure that individual practice presumes that an individual has mental capacity to make a decision, and that the individual is the first and primary point of contact with whom the experience of alleged abuse should be discussed.

- That individuals with a learning disability are asked for their views and opinions including where there are allegations of abuse and potential for conflict between the expectations of individuals and their families.

- That awareness is developed that until an abuse alert is raised, the adult protection process and roles within it, are not in place; responsibility for an informed, reasoned decision rests with the professional who has identified the potential abuse.

- That nurses and social workers recognise the influence of relationships upon their practice and decision-making and are supported to undertake a reflexive self-evaluation and to become reflexive selves (Miehls and Moffat, 2000).

- That supervisors of nurses and social workers are alert to, and challenge, the influence of relationships with family/friends of adults with a learning disability in defining abuse.

7.8 Concluding comments

The findings from this study in relation to allegations of abuse indicate that there are a number of influences upon the decision-making process of nurses and social workers in CLDTs in South Wales.

Situational Analysis (Clarke, 2005) provided a grounded theory approach to explore, consider, map and analyse the adult protection decision-making

experience of participants. Using Situational Analysis, (Clarke, 2005) I was able to explore the experience of nurses and social workers, first hand. The opportunity to undertake this research and the generosity of participants who gave their time, and shared their experiences openly and honestly was greatly appreciated. The data that interviews with participants presented indicated that it is very much a reality of practice in a CLDT and that there is a tipping point in decision-making and determining action, at this point practitioners exercise discretion and managers decide.

Beliefs about how adult protection procedures should work were expressed by participants, although these were frequently mismatched with policy intention and practice direction. These participant views are valued contributions towards the new theory presented in this thesis. With an enhanced understanding of safeguarding decision-making that this new theory presents - that practitioners exercise discretion and managers make decisions-a clearer understanding of influences upon nurse and social worker decisions is achieved.

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Appendix 1 – Interview guide sheet

What influences decisions made by nurses and social workers in CLDTs in Wales when responding to potential allegations of abuse?

Introduction: welcome and sign consent from, participant sheet available

Question	Prompt
Introduction: Can you tell me a bit about your role and experience of adult protection to date?	
What do you feel are the influences upon social worker and nurse decisions in relation to adult protection?	• In Safe Hands • Local policy • Manager • Colleagues • Relationship • Trust • Resources • Funding • Codes of conduct

What are the practitioner views of accountability for adult protection?	• Registration • Litigation • Shared • Lead responsibilities • Loyalties • Code of practice • Policy • Time commitments • Blame/accountability
What are the priorities upon decisions for action/non-action.	• • Risk assessment • Change – what changes Advice of colleagues • Immediate danger • 999 • Case management
Are there things that you think are important to adult protection practice?	
Check : **Is participant happy for the information to be used in the research?**	

Developments of prompts over research project:

- Peer support
- Support for a decision
- Care and support orders – duty to assess
- Changing legislation Mental Capacity

Appendix 2 - Participation information sheet

Responding to allegations of abuse. A qualitative study of the influences upon decisions made by nurses and social workers in CLDT's in Wales.

I would like to invite you to take part in a study into the responses of registered nurses and registered social workers in a community learning disability team when an allegation of adult abuse is received. You have received this information because you work in a community learning disability team. The research invites the participation of registered nurses and registered social workers who have been in post for at least one year.

Please read this information sheet to help you to decide if you would like to take part.

Who is carrying out this study and how is the study supported ?

The study is part of a PhD study. Zoë Hodges is undertaking this research as part of MPhil/PhD study. The research has been approved by the University of Glamorgan and has gained NHS ethical approval. Ethical evaluation from the Association of Directors of Social Services has also been gained. The research project is supervised by Professor Ruth Northway and Dr Lee Quinney, University of Glamorgan.

Why is this study important ?

Understanding how nurses and social workers respond to allegations of adult abuse is crucial to developing effective multidisciplinary adult protection decisions. There is little existing research available to explain what motivates the decisions that nurses and social workers in a community learning disability team make.

This is an opportunity to discuss the work that you undertake.

What will my participation involve?

The research student, Zoë Hodges, will contact you to arrange a time and place that is convenient to meet to discuss your experience in adult protection decision – making.

You will be asked to complete a consent form and to complete a demographic information sheet – this is information about your role, length of employment, or qualification, for example. Your participation will involve an interview, to be recorded with your consent. This interview will last between 50 minutes and 1.5 hours.

You do not have to take part. The research is not connected to your employer.

If you withdraw from the study any information that identifies you will be destroyed immediately. If at the end of the interview you no longer wish to take part, your information will be destroyed.

There are no identified direct benefits to you. The intention is that the research will inform and contribute to social work and nursing adult protection practice. You will be asked by the researcher at the end of the interview to confirm if you are still happy for this to have your comments included in the study. After this point it is not possible to remove your contribution as the data will already have been included in the analysis.

Confidentiality and anonymity.

Your name is removed from the interviews when they are transcribed, you will be given a pseudonym so that you cannot be identified. This means that your contact details will not be linked to your interview. Information that identifies the participant will be removed following the interview. Confidentiality of your information will be respected and the data used only for this research, the report of findings and publications that result from this research. For research use you will be allocated a code, to protect your anonymity. You are welcome to a summary of the research upon completion.

All transcribed information will be held securely in accordance with the data protection act and the policies of the University of Glamorgan. This includes password protection of computer based information and the locked storage of non- computer materials.

However, in the event that adult abuse or poor practice that has not previously been identified is identified the relevant adult protection coordinator/lead nurse or line manager will be notified. Please consider this when you decide whether to take part in research. The researcher is a registered social worker, working in accordance with the requirements of the Care Council of Wales Code of Practice.

If you have further questions about your participation or the study itself please do not hesitate to contact either the researcher or the supervision team.

Zoë Hodges zhodges@glam.ac.uk

Professor Ruth Northway rnorthwa@glam.ac.uk(01443) 483177

Dr Lee Quinneylquinney@glam.ac.uk(01443) 483842

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Appendix 3 Faculty ethical approval

University of South Wales
Prifysgol De Cymru

Professor Julie Lydon Vice-Chancellor

15 May 2012

Ms Zoe Hodges
c/o Faculty of Health, Sport and Science

Dear Ms Hodges

Re: Responding to allegations of abuse. A grounded theory study of the influences upon decisions made by nurses and social workers in Community Learning Disability Teams in Wales.

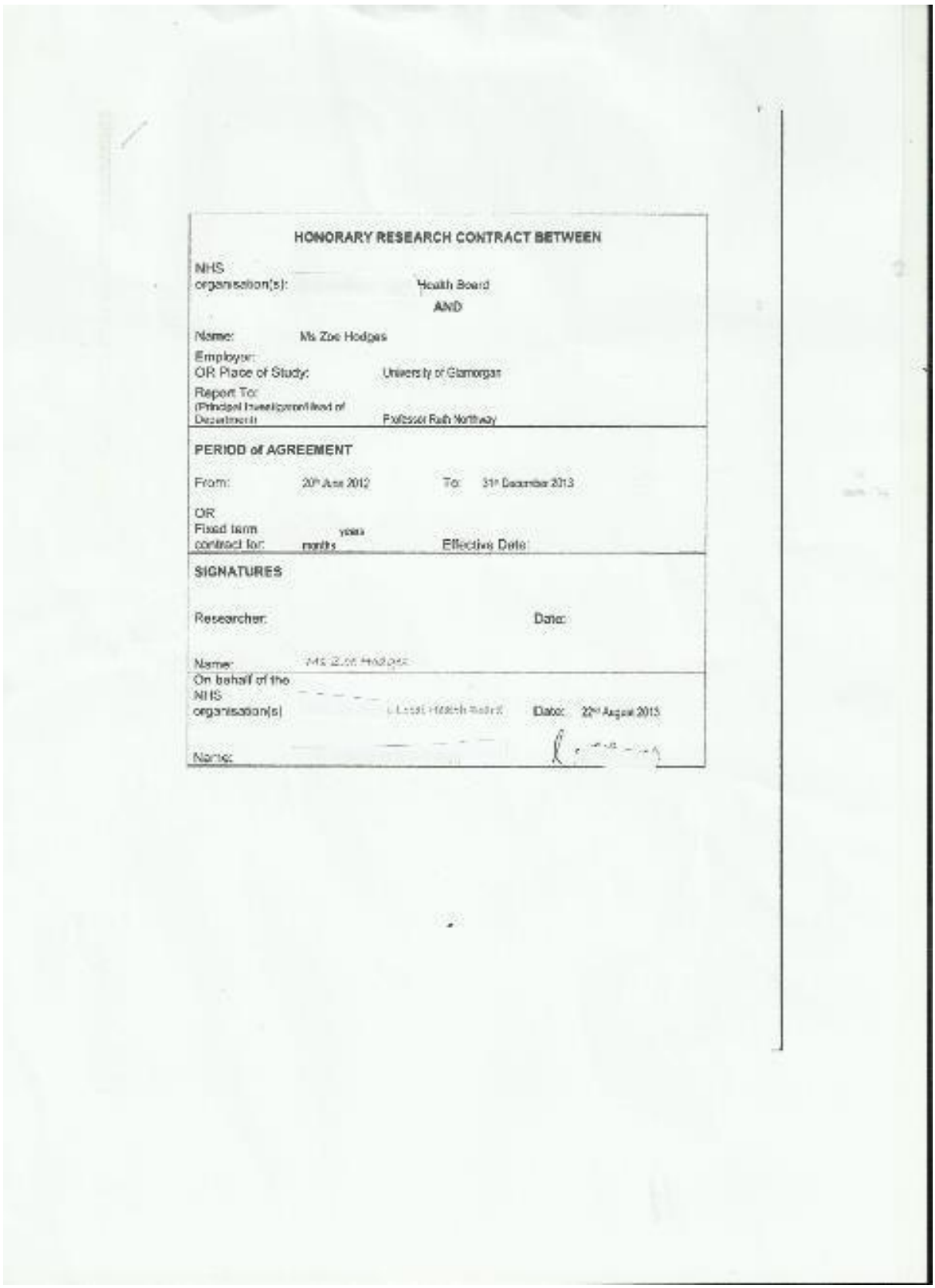
I am writing to confirm that on the 14 May 2012, the Faculty of Health, Sport, and Science Ethics Sub Group approved your submission for ethical approval.

If you have any queries about the group's decision, please do not hesitate to contact me. Please note: when changes are made to an already approved protocol the opinion of the Faculty Ethics Champion must be sought.

Yours sincerely,

Dr.
Faculty Ethics Champion

Appendix 4 Research Passport/Honorary contract



HONORARY RESEARCH CONTRACT BETWEEN

NHS organisation(s): Health Board

AND

Name: Ms Zoe Hodges

Employer:
OR Place of Study: University of Glamorgan

Report To:
(Principal Investigator/Head of Department): Professor Ruth Northway

PERIOD of AGREEMENT

From: 20th June 2012 To: 31st December 2013

OR
Fixed term contract for: years months Effective Date:

SIGNATURES

Researcher: Date:

Name: Ms Zoe Hodges

On behalf of the NHS organisation(s): Local Health Board Date: 22nd August 2013

Name:

Appendix 5 Consent form

Responding to allegations of abuse. A qualitative study of the influences upon decisions made by nurses and social workers in Community Learning Disability Teams in Wales.

Consent Form

Please read carefully the following questions, tick the boxes and then sign and date the form:

I have been provided with a copy of the Participant Information Sheet [ ]

I have had the opportunity to ask questions about my participation [ ]

I agree to take part in an interview [ ]

I agree to the interview being recorded and transcribed [ ]

I understand that the researcher will anonymise all aspects of my participation [ ]

I understand that my information will be stored in accordance with the

Data Protection Act 1988 and the requirements of the University of Glamorgan [ ]

I agree that my anonymised comments may form part of the Project Report[ ]

I agree that my anonymised comments can be used in publications and [ ] conference

presentations and teaching.

I understand that the information I is confidential unless poor practice or abuse [ ] is

identified.

Signature……

Name (printed)……

Date……

Signature of Researcher…….

Appendix 6 – ADSS Cymru; email of introduction

From:
Sent: 13 August 2012 17:09 **To:**
Hodges Zoe **Subject:**
RE:

Hi Zoe

I discussed your research with (name removed) this afternoon. He is more than happy with the subject and the approach. He was clear however that ADSS Cymru can't give formal approval as the decision participate is specific to each Local Authority.

I would suggest that you contact each Director accordingly

In the meantime I will forward your proposal to (Names removed) who are the lead Directors for ADSS Cymru in relation to safeguarding.

Appendix 7 - Metasearch : database comparison sets University of Glamorgan 2012

Database comparisons : CINHAL, ASSIA and Ingenta databases

Search timeframe	Terms	Return (duplicates removed)
1/1/1983 - 31/12/2012	Decision, Learning Disability, adult abuse, Wales	25
1/1/1983 - 31/12/2012	Decision, Learning Disability, adult abuse NOT child	25
1/1/1983 - 31/12/2012	Intellectual disability, adult, abuse NOT child	34
1/1/1983 - 31/12/2012	Learning disability, adult, abuse NOT child	74
1/1/1983 - 31/12/2012	Intellectual disability, policy, abuse NOT child	32
1/1/1983 - 31/12/2012	Intellectual disability, policy, abuse NOT child	60
1/1/1983 - 31/12/2012	Wales, safeguarding, adult	21
1/1/19833 - 31/12/2012	Learning disability, safeguarding, adult	14
	Total	**285**

Appendix 8 - Example of identification of initial codes from transcription of participant interviews

Interview text	Nvivo codes identified

A: What sort of reason would people want to remain anonymous?	
B: There's all sorts of reasons our nurses have an obsession with maintaining a good relationship with people they think we don't need to maintain a good relationship but they must and that is usually they're excuse that would be their excuse not just with POVA but with any difficult conversation	**Relationship**
A: Does that mean that it's seen as a sanction that if you get social services involved that you use this process it's a –	
B: Yeah to some extent […] also I have to have discussions I don't know if you're going to me question because you're going to be coming back [No no you go for it] people will have discussions are people will want to use a POVA inappropriately to bollock someone with and that's when you get in discussion about thresholds	**Quality concerns/poor practice**
A: So what sort of thing would influence the threshold then?	
B: Yeah it's a really useful guide prompt if you like so that'll always b my first port of call to say well accordin to this where's that coming on the then we'll use your thresho - that's largely going to be experienc neone's coming to me or to us as a POVA then we'll say well let's look at he threshold and between us what we know of that person what we know of t discuss it a potential ly dynamics what we know of the iips within anywhere they go of probability but there are occasions	• **Prompt** • **Guidance** • **Accountability** • **Relationship** • **Family/carer** • **Other process**

	ı can say it's just simply not going tc ɜ threshold it's not going to go tc ːe so	

that will be care management we need to organise an old fashioned case conference rather than a POVA	

A: And is that about resources or is it about as you suggested that it is used as a sanction but also to move some of the responsibility or –	

B: I think both they want to remove the responsibility I can see the point in that really I can see why it's attractive to people because they can say well here's a collective who are making who are agreeing and the level of risk and where we go next so it's a comfort and a safeguard for people it's not a comfort or a safeguard for the poor bugger that's on the DLM rota who's going to deal with an inappropriate referral and you have to be quite tight I think or people will say well I don't like we had it last week in the team meeting where someone has been excluded by day services run by leisure completely inappropriately and having discussions about the way forward to make sure this doesn't happen again and to make sure that they follow correct procedure but they don't have correct procedure because they're our own leisure services who day services place people all sorts all sorts of things wrong with it so we're having discussions about what do we do where do go who do we go to we've had discussions that have been unsatisfactory so the answers from nurses was well have a POVA and I said we can't really have a POVA on that about that because noone's actually we can't pinpoint any abuse on her it was an incorrect what I've got there is an issue with day services placing people we're not treating our own staff as we would external staff [and that is] about training and placing people with correct training and taking accountability and	**Collective** **Accountability** **Comfort** **Other VA roles** **Threshold** **Risk** **Care management/VA** **Guidance** **Other process** **Quality/poor practice** **Care management/VA** **Accountability** **Sanction**

[probability] it was interesting from social services side we were having a look waste of time going down the	

correct route because we wouldn't get anywhere but we could get somewhere with another route which we had to determine we didn't have all the answers the nurses were adamant no somebody needs to be hammered with this someone needs to be held to account wanting someone to blame and a head to roll and the only way to do that was via a POVA at least try to explain well when you phone that through as a referral and the POVA coordinator picks it up she's going to go through the thresholds and she's going to say that's [one] for case management	
A: I've studied equality concerns with provider and training	
B: That's just the latest example there's not the most [?] actually but it's things like that that come up quite a lot they're not happy with even when a process has been carried out correctly if they haven't liked the outcome well you know that's not fair because you've been discriminated against got a learning disability got a POVA I say well correct procedures will follow if you didn't meet eligibility criteria or or someone's own behaviour has caused it to be excluded after a series of warnings	

Appendix 9 – Example of reflective memo completed during initial findings (May 2014)

May 16th - overlaying comments on the management **positional map** association that SW seek management advice whilst nurses seem to discuss in supervision.

- Far stronger comment in this position from social workers than nurses.

- Might nurse indicate that they come back and discuss with the social worker – some comments endorse this? **Revisit data**

    - Conflict in SW 11 position negotiation with a **management override.** (first time emergence but then repeated – supervision discussion and data checking required)

    - **Impact of practitioner perception of relationship**: Nurse/social worker and service change in the lower axis - at supervision it had been discussed whether this might be quality of relationship but there is some conflict around quality of relationship – working together – agreement? Ability to get over the house threshold? This then includes that there can be a perception of a good relationship but no agreement – and therefore increased likelihood of VA action – the idea of waiting for the right opportunity. ? – **re-search literature.**

    - **Relationship:** position 4 – high likelihood of referral and good relationship – relief a feature.

    - **SW 21**: we're unhappy with this – language - **ownership...** ? Individual – collective – **organisational?**

    - **Relationships**: position 3 - difficult to comment as there is no perception of a relationship which will influence.

    - Comments reflect a fairly even professional spread. In position 5 (negotiation) there is a greater presence of nurses (given the ratio of participants) . Is the negotiation a fit with a conversation with social care staff before making a referral? **Deferring** the decisions?. **Do relationship and management overlap on this one?**

Appendix 10 – Glossary

Abuse : 'A violation of an individual's human and civil rights by another person or persons which results in significant harm' (In Safe Hands, NAW, 2000)

Adult protection : A term used to refer to the prevention and response to abuse. It may be mostly associated with the process of policy and process.

CLDT : Community Learning Disability Team.

CNLD : Community Nurse, Learning Disability (see RNLD)

Constructivism : A perspective on how views are formed, participants and researchers construct the realities in which they are a part. Interpretation of the studied phenomenon is also a construction.

CSSIW : Care and Social Services Inspectorate Wales. The regulation and inspection body for Wales.

DH : Department of Health

NAW : National Assembly of Wales**.**

POVA : Protection of Vulnerable Adults – usually referring to the process and policy.

RNLD : Registered Nurse, Learning Disability

Safeguarding : An approach that includes policy and process responses but also advocates the right to be safe by increasing opportunities for involvement and justice.

Significant Harm : Ill-treatment (including sexual abuse and forms of illtreatment that are not physical); impairment of, or an avoidable deterioration in, physical or mental health; and/or impairment of physical, emotional, social or behavioural development.

Threshold (adult protection) : The point of recognition and action that formal adult protection action is required.

Vulnerable adult : is a person over 18 years of age who is or may be in need of community care services by reason of mental or other disability, age or illness and who is or may be unable to take care of himself or herself, or unable to protect himself or herself against significant harm or serious exploitation.

WAG : Welsh Assembly Government.

WG : Welsh Government (from May 2011)